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Nursing Law and Ethics

Edited by A. Carmi and S. Schneider

With Contributions by
M. B. Agostino K. Asplund B. Bandman E. L. Bandman
R. Bergman K. M. Boyd A. V. Campbell A. Carmi
R. Crow A. J. Davis M. deChesnay E. Dixon R. Eldar
M. J. Flaherty S. T. Fry C. P. Germain L. C. Greif
I. H. Haugen L. Hockey S. Kottek M. Levine
U. Lowental M. S. Macmillan D. Michaeli A. Norberg
K. M. J. Rea S. M. Roach S. S. Rosario J. Rosenkoetter
M. Rosenkoetter J. Sansoni R. A. Schröck K. Scherer
C. Searle V. B. Shachar Y. A. Shapira S. A. Smoyak
C. Sùs H. O. Thompson J. B. Thompson L. R. Uys
N. Wagner

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Judge Amnon Carmi
P. O. B. 6451, Haifa 31063, Israel

Prof. Dr. Stanley Schneider
Summit Institute
Wurzweiler School of Social Work, Yeshiva University
Michlala Jerusalem, Women's College
P. O. B. 7446, Jerusalem, Israel

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Contents

List of Contributors

M. B. Agostino
Via Pienza 201, I-00138 Rome, Italy

K. Asplund
Department of Advanced Nursing, S-901, 87 Umea, Sweden

B. Bandman
Long Island University, Brooklyn, NY, USA

E. L. Bandman
Hunter College of the City, University of New York
3341 Reservoir Oval, Bronx, NY 10467, USA

R. Bergman
School of Nursing, University of Tel Aviv, IL-Tel Aviv 63474, Israel

K. M. Boyd
Society for the Study of Medical Ethics, 1 Doune Terrace
GB-Edinburgh EH3 6DY, Scotland, United Kingdom

A. V. Campbell
Faculty of Divinity, University of Edingburgh, Scotland
United Kingdom

A. Carmi
P. O. B 6451, IL-Haifa 31063, Israel

R. Crow
Nursing Practice Research Unit, Northwick Park Hospital
Watford Road, GB-Harrow, Middlesex, United Kingdom

A. J. Davis
School of Nursing, University of California, San Francisco
CA 94143, USA

M. deChesnay
School of Nursing, Emory University, Atlanta, GA 30322, USA

E. Dixon
School of Nursing, Guy's Hospital, GB-London, SE 1, England
United Kingdom

R. Eldar
Faculty of Health Sciences, Ben Gurion University of the Negev
Beer Sheva, Israel

M. J. Flaherty
Department of National Health & Welfare, CDN-Ottawa, Ontario
Canada

S. T. Fry
Kennedy Institute of Ethics, Georgetown University, Washington
DC 20036, USA

C. P. Germain
School of Nursing, University of Pennsylvania, 420 Service
Drive/S2, Philadelphia, PA 19104, USA

L. C. Greif
Department of Nursing, Tel Aviv University, IL-Tel Aviv 63474
Israel

I. H. Haugen
Nursing Division, The Health Sciences of Norway, Oslo, Norway

L. Hockey
Nursing Research Unit, Department of Nursing Studies, University
of Edinburgh, GB-Edinburgh, Scotland, United Kingdom

S. Kottek
Department of the History of Medicine, Hebrew University
Hadassah Medical School, IL-Jerusalem 92-585, Israel

M. Levine
550 Sheridan Square, Evanston, IL 60202, USA

U. Lowental
School of Medicine, Hebrew University, IL-Jerusalem 92-585
Israel

M. S. Macmillan
Nursing Studies Research Unit, University of Edinburgh
GB-Edinburgh, Scotland, United Kingdom

D. Michaeli
Ministry of Health, Ben Tabai 2, IL-Jerusalem 92-585, Israel

A. Norberg
Department of Advanced Nursing, S-901, 87 Umea, Sweden

K. M. J. Rea
GB-Brentwood, Essex, United Kingdom

S. M. Roach
St. Francis Xavier University, Antigonish, CDN-Nova Scotia
B2G 1CO, Canada

S. S. Rosario
Clinica Universidad de Navarra, E-Pamplona, Spain

J. Rosenkoetter and M. Rosenkoetter
Columbus Country Mental Health Center, Whiteville, NC, USA

J. Sansoni
Via Pienza 201, I-00138 Rome, Italy

R. A. Schröck
Dundee College of Technology, GB-Dundee, Scotland
United Kingdom

K. Scherer
647 Broadway, Winnipey, CDN-Manitoba R3C OX2, Canada

C. Searle
University of South Africa, POB 392, ZA-Pretoria 0001
South Africa

V. B. Shachar
Ministry of Health, IL-Tel Aviv 63474, Israel

Y. A. Shapira
10 Abraham Shapira Street, IL-Natanya, Israel

S. A. Smoyak
4 Ronby Road, Edison, NY 08820, USA

C. Sùs
Subiron, Clinica Universitaria, E-Pamplona, Navarra, Spain

H. O. Thompson and J. B. Thompson
School of Nursing, University of Pennsylvania, Philadelphia
PA 91104, USA

L. R. Uys
University of Orange Free State, ZA-Bloemfontein 9301
South Africa

N. Wagner
Tel Aviv University School of Nursing, Kaplan School of Nursing
IL-Tel Aviv 63474, Israel

I. Introduction

Nursing: State, Status and Statutes

A. Carmi

1 The Whole Truth

"Courts of Justice seem to think that anybody can speak the whole truth, and nothing but the truth. (However), it requires many faculties to speak the whole truth, and to say nothing but the truth."

This statement was not made by a learned judge, but written by Miss Florence Nightingale, the lady with the lamp, in her "Notes on nursing - what it is and what it is not", about 125 years ago.

The whole truth about nursing is not to be found in any court decision or statute or in any declaration, nor is it to be determined solely by doctors or to be formed by public opinion. Theirs might be the truth, but not the whole truth.

The crucial issue, the most important question, will always be: what do *nurses* think of themselves, and what will *nurses* do for themselves.

2 History

The whole truth about nursing is reflected by its comprehensive history. The development of the nursing image has a long history.

Whereas *criminal* literature describes *prostitution* as the oldest female occupation, nursing records insist that *nursing* is the oldest of the professions of women, with its roots to be found at the cradle of mankind. As there has always been disease, nursing started where man began to care for the sick.

The Old Testament describes various paranursing activities: Rebekah's nurse accompanied her when she left with Abraham's servant to meet Isaac, and the prophet Isaiah stated: "thy daughters shall be nursed at they side" (60:4).

Ancient Jewish law dealt with health and disease and took the first steps toward prophylaxis.

Institutional nursing had been formally established by Christianity, particularly through the Christian concept of charity with its origins in the Jewish tradition. The Hebrews organized charitable societies for supporting the sick, while the Christians built hospitals and maintained them. Some of their oldest hospitals were built in Israel. Basil, the Bishop of Caesarea had already founded his hospital in 370 A.D, with the institution named after him: the Basilias. Its staff consisted of physicians and nurses. In the beginning of the 12th century, Brother Gerard had built a large hospital in Jerusalem which was kept by the Order of the Knights of St. John. Other hospitals were founded by the Crusaders in Jerusalem and Acre in those years.

3 Sex in Nursing

During the course of history, various factors took part in the formation of the nursing image, with sex being one of the most important aspects in role differentiation.

With the experience of the past, bias and suppression should not be ignored by those who strive for a substantial change. The secondary position of women in the past and even in the present society has affected the legal, economic, and professional status of nurses. Nursing has always been influenced by social conceptions inferring that women were less independent than men. Nursing was excluded from the decision-making roles; these roles were kept in the hands of males. The subjection of nurses was coincident with the subjection of women. Considering the fact that more than 90% of all nurses are women and that society under the general masculine supremacy was not prepared to grant high status to women, nursing had to struggle in order to be acknowledged as an important professional group.

Nurses should be aware of this phenomenon if they desire to put an end to the discriminatory process. Nurses treat doctors (and females treat males) much the same way as doctors see nurses as women with whom they work. The process of change of attitudes must start within the nursing profession through self-education. It is worthwhile indicating that many nursing schools still teach their students to fulfill submissive roles. They are trained to show strict obedience, which brings about subordination and dependence.

Some psychologists claim that the nurses' urge to treat the sick originates from the mothering instinct and that nursing is therefore part of feminine nature.

However, nursing should not be given an inferior status, even if it consists of some female traits according to this (male-oriented) psychological theory. In conclusion, if the nursing profession strives to improve its position, nurses must be aware of this problem and, accordingly, maintain their public campaign and the education of their next generation.

4 Who Is More Important?

There is no way to measure or determine the importance of nursing. Every statement depends on various questions, such as: "What is the purpose of the question" or "Important to whom?" However, the importance of a profession is determined *inter alia* by the reflection of its image and its status.

Any project purporting to raise the nurses' status cannot disregard their present image. Different images of nurses are conceived and reported by various groups of patients, physicians, and nurses. Preliminary research, which has been recently conducted in Israel, presents the attitudes of five different communities with regard to the importance of nursing. The research comprises the views of 120 physicians and nurses, of 120 students of medical and nursing schools (3rd year), and of 390 patients from various hospitals.

One of the questions presented to the participants was: Who is more important: doctors or nurses? Several persons, especially doctors, replied in an aggressive manner: How could anyone present such a silly question? Others were more patient: Everyone may be important in his own field or activity. The emotional reactions were of most interest to us, but we turned to examine the other replies as well.

For both the patients and their physicians, 70% were of the opinion that doctors are more important than nurses. Only 5% of the doctors and 20% of the patients stated that nurses are more important than doctors. The following replies were the most interesting ones: Of the students in nursing school, 60% claimed that doctors are more important. However, they can be expected to change their attitude shortly, since only 30% of the registered nurses were of the same opinion.

Another part of the questionnaire dealt with the question: How are doctors behaving toward nurses? Physicians (80%) and patients (81%) were definitely satisfied. Nurses (63%) and nursing students (57%) were less content.

The next question was: Should anything be done so that physicians will treat nurses in a better way? Both doctors and patients (62%) believe that there is no need for any improvement. Nurses (82%) and nursing students (90%) emphasize the need for a radical change.

It is interesting to indicate the different replies given by young people of approximately the same age: Medical students hold (74%) that doctors treat nurses in a proper manner and that there is no need for any improvement (60%). On the other hand, nursing students are of the opinion (43%) that many doctors do not behave properly toward nurses and that a big effort should be made in order to make things better (90%).

This gap reflects the difference of opinions and the lack of mutual understanding which already exists among the young members of the medical and nursing professions.

What about the behavior of nurses toward doctors? Patients seem to be content (93%) and nurses feel the same (93%). Physicians are less happy (71%), and the replies of the medical students (69%) perhaps express their well-known fear of the older and more experienced nurses. Various replies were supplied to the next question: Should anything be done in order to improve nurses behavior toward physicians? Of the doctors, 86% claim that a real change should be made. This attitude reflects the doctors' convinctions that it is the nurses' task to do their utmost in order to raise the level of the doctor-nurse relationship. Nurses may disagree with such a sweeping assumption, but they should not disregard it because the improvement of that relation depends upon both parties.

It is worthwhile mentioning, however, that not less than 70% of both nurses and nursing students admit that nurses should improve their behavior towards doctors.

Various factors are involved and applied in the campaign for better wages or higher status, including the nature of the work and its burden or level of difficulty. Diverse replies have been given by nurses and physicians with regard to the question: Whose work is harder? Of course, there is no scientific way to measure this issue, nor are there any objective criteria, which may supply the "correct" answer. The only reason for this question was to evoke certain emotional reactions and examine them.

Thus, physicians state (62%) that *their* work is harder, while nurses claim (73%) that *their* work is harder.

Of the doctors, 31% admit that nurses work harder than they, but only 7% of the nurses agree that physicians work harder than they. Concerning the younger generation, we found that 88% of the nursing students believe that nurses work harder, while less than half of the medical students (32%) hold the same view. These replies show the power of education, or if you wish, "brain-washing," which is applied at different schools. Last, but not least, patients believe that nurses (68%) work harder than doctors (22%).

And, finally, most of the patients prefer female nursing treatment to male treatment (62%; doctors even 78%!), but the patients prefer male medical treatment (57%) to female treatment (28%).

What should be done in order to improve the relations between nurses and doctors?

Most of the participants indicated the need for forming better mutual relations within the clinics and also outside the working frame, such as social meetings, parties, etc. We have collected various suggestions, including the exchange of information of working procedures, attending seminars and advanced studies, taking part in clinical discussions, and planning treatment together, Maybe the most important suggestion was to teach doctors and nurses how to function properly in an interdisciplinary staff. No less important was the claim for mutual understanding and respect.

However, one cannot disregard the pessimistic views of various desperate participants. Some physicians content themselves only with the increase of the *nursing* level.

Several physicians complained about their low earnings, and one doctor stated that nothing will be changed unless nurses change their character. A young medical student proposed to fire every nurse who has reached the age of 30, and his sex-minded colleague explained that doctors start their relations with nurses near the bed (of the patient) and end it on the bed.

Nurses, on the other hand, admitted that they should primarily acknowledge their own value. They demanded that physicians should accept the fact that nurses are human beings. One nurse suggested that doctors take part in the process of making tea or coffee in the clinics. Another young and frustrated student exlaimed that no improvement should be expected until the doctors would at least conceive that nurses are not just fool creatures.

5 What to Improve?

The self image of the nurse appears to be at fault, as Hinsvark cynically stated: "Where the doctor walks in, the nurse walks out."

Physicians could never have attained their domination of nurses if the nurses had not allowed it. Apparently, many nurses are still afraid to take risks, to make decisions, and to treat patients even when they are entitled and capable to doing so. In the process of modification, the change of image should start at home. Nurses must assume their responsibilities in order to form a different image of themselves and for themselves. Only then should their true image be presented and promoted to the physicians and to the public at large.

Social status is not given, but gradually assumed or attained. Nurses will feel an increase in their status while assuming a larger role within the community of the health professionals.

Very soon we shall confront a growing demand for nursing care. Such a demand will derive from various social and economic sources: the growth in population, the growing interest in one's state of health, new patterns in the delivery of health care, and even rising medical costs.

Nursing should grow and exhance itself through self-education and self-training. This can be expanded into the challenges for a higher status, and looking forward to emerging as a dominant factor in the field of health maintenance.

It is commonly accepted that the essence of a profession is that it is an organization of an occupational group based on the application of special fields of knowledge, with its own rules and standards for the protection of the public and professionales.

What is urgently needed for the nursing profession is a new definition of both the framework and its' contents. The range of functions should be expanded and the scope of nursing should be broadened in order to meet various demands. The profession has changed throughout history, paralleling the needs of society. Public awareness of scientific advances during the last century has created demands for better services. Health and high levels of standards of health have been acknowledge as fundamental rights of every person. The changing role of nursing should therefore be perceived in the same terms. Health care is provided by many health disciplines and is not just limited to the treatment of illness or disability. It comprises therapeutic care, health maintenance, preventive treatment, restorative measures, and health education.

In order to be recognized as a dominant factor in the field of health care, nurses have to build and define their unique role.

Physicians control the decision-making process with regard to the care of the patient. They stand at the top of the pyramid of the health professions, keep the monopoly, and dominate the field. Medicine may put obstacles in the path of nursing's efforts to expand its role and to become an independent profession of higher recognized status. Physicians are not prepared to regard nursing as significant as medicine. Also, economically they prefer to keep the control over the health care system in their hands. In the past nurses had only fulfilled the directions of the doctors, who had applied absolute authority and control of both the treatment and the nursing of the patients. Any expansion of the nursing activities may infringe on those activities, which had previously been carried out by the medical profession. It is the overlapping areas that cause the trouble.

Nurses will find it difficult to challenge the dominant role of the doctors in the fields of diagnosing illness and curing disease. They should try, therefore, to function autonomously in other areas of health care while continuing to carry out the physicians' instructions.

Figuratively speaking one may draw two circles. The smaller circle represents medicine, which deals mainly with illness, and the larger circle represents health care, as provided by all health disciplines. Nursing, emerging from its secondary role in the small circle and entering the wider field as described in the second circle, may find *there* its real identity and fulfill *there* its full role.

This type of nursing may deal with the personal and social needs of the patient and his family, the preparation of health care programs, health counseling and health teaching, as well as health research. In particular, nurses will have the immediate contact with people entering the health care system, deal with the care of healthy children or older people, undertake the care of healthy women throughout their pregnancy, treat patients with commonly occurring health problems, and advise people on health matters.

It is unlikely that either the physicians, whose traditional role is challenged, or members of other health disciplines will be prepared to willingly accept this nursing concept. However, the ever-growing shortage of physicians, especially in general practice and in general pediatrics, and the unavoidable medical concentration on sick care activity might help nurses in their campaign.

Nursing now has a real opportunity to become a dominant factor, forming the kind of health care system which will meet the needs of the public and extend care to larger numbers of patients.

6 How to Improve

The status of nursing will be improved if nurses try to effectuate change in the following five areas:

1 Selection of students. Modern procedures, which will guarantee the admission of the best-qualified students to the nursing schools must be applied.

Miss Nightingale criticized what she called a commonly conceived idea: that it requires nothing but a disappointment in love or the want of an object to turn a woman into a nurse. She cynically indicated the case of a stupid old man who was set to be a schoolmaster because he was "past keeping the pigs."

Judges in courts of justice are taught that they should not limit their compassion to the *defendant* only. They should show mercy to his victim too. Similarly, while checking the qualifications of the applicants to nursing schools, the examining boards should show some mercy to the potential patients too. Attainment of high standards from the beginning will ensure the success of the whole journey.

2 Education will always be the most important factor. Advanced systems of nursing education and training must be persistently looked for and formed, in order to raise the professional level.

Nurses should consistently update their knowledge, and continuing education must be required for relicensure.

3 Better treatment. Florence Nightingale stood for the principle: "Nurse the sick, not the sickness." The two following illustrations reflect her idea more than volumes of sophisticated theories: Never allow a patient to be woken, and always sit within the patients view so that he must not turn his head around to look at you. In other words, do not look upon patients as made for nurses, but upon nurses as made for patients. Regard your patient as the most important person in the hospital.

Patients will be the key persons in the determination of the status of nursing in the future. The communities of sick people will take part in the formation of society's attitude toward nursing. Therefore, better treatment for the sick will also improve the image and the status of nursing.

4 Better relations with doctors. The status of nursing will be partly formed or influenced by doctor's attitudes. The relationship between nurses and physicians will always remain a most important factor in the health care system. The attitudes of both doctors and nurses might be modified through the process of education. This kind of education should be the mission of the leading authorities in the schools of medicine and nursing.

5 Increasing authority and responsibility. Nurses are legally obliged to use reasonable care, which will be determined according to the common practice. Misapplication of any activity which is within the scope of the nurse's responsibility, or failure to carry out such a duty, might be regarded as negligence. On the other hand, nurses should not undertake to perform anything which is beyond their qualifications or to function in an unauthorized extended role.

Licensure laws are enacted in order to protect the public's health and safety. Their purpose is to ensure that nurses are able to apply reasonable standards of practice. The expansion of the scope will carry heavier responsibilities on the part of the nurse. It is a must that nurses be trained and prepared to bear the burden of such a responsibility.

New laws can be expected to grant autonomy and authority to nurses. Nevertheless, one should not regard legislation as the primary solution. Until now the only purpose of nursing licensure acts was to protect the public from incompetent nurses. Much preparation is required for the enactment of new laws which will protect nurses and provide them with the right to practice as independent practitioners. Legislatures have little or no knowledge of nursing dilemmas. They should be educated and public opinion should be formed.

The application of such laws will meet many difficulties. Substantial funding will be required for the education of all nurses. Comprehensive health treatment by nurses will also be a cause for difficulties. Various groups of physicians and health practitioners, as well as injured patients, may legally challenge the nursing profession. Governments and courts emphasize consumer rights and tend to compensate injured persons for all types of damages. Unreasonable expectations of patients with regard to the capabilities of nurses may bring about frustration and aggressive reactions. Nurses should understand and accept that rights carry duties and that independence means responsibility.

7 Conclusion

Nursing is on the verge of crucial changes. It has to face many difficulties. Dreaming and hoping für a better future will not suffice. Even "the coolness of the soldier and the tenderness of the mother" will not do. New approachs are required for meeting nursing's needs. Nurses should strive to attain self-awareness and self-education. And, last but not least, they should initiate not only a new kind of relationship with the medial profession but a close cooperation with jurists who know nursing laws, who are aware of nursing dilemmas, and who are ready and able to devote their skill and show their goodwill for the advancement of nursing.

II. Nursing: Legal Aspects

Introduction

The papers in this section on the legal aspects of nursing can be divided into two parts: (a) the rights and responsibilities of nurses, patients, and the medical system and (b) treatment, with its legal ramifications.

How does one decide whether patients' rights or the health professional's rights are to be considered more seriously? Is there an absolute "right" or "wrong"? Since legal rights are sanctioned by constantly changing social and political climates, this may, in effect, diminish the possibility of anything absolute.

The question of the "equivalency" of legal and moral rights is also addressed. Due to the prevalent vagueness with regard to bioethical issues as they affect human and legal rights, often we become absorbed in philosophical polemics without being able to arrive at any one answer. In order to move beyond the ethical/theoretical formulations, there is daily confrontation in the nursing profession - the practical application of theoretics.

The nurse, as a professional, wants to be viewed with professional status. This necessitates a contractual agreement with patients, colleagues, and society as a whole. This job status allows decisions to be made with professional weight behind them. It also involves greater responsibility on the part of the nurse. Thus, violation of patient self-determination in order to protect his best interests may be a type of decision that the professional nurse may have to make. In addition, the countertransference feelings of the nurse have to be taken into account, for individual biases may affect how the nurse deals with patients.

Confidentiality is a value that is both ethically and professionally governed. However, should professional secrecy "protect" the patient by keeping certain information unavailable to him? What are the rights of patients - especially the mentally ill? Are these rights ethically/morally and/or legally governed?

When addressing such philosophical issues, the question of practice/malpractice arises. The treatment professionals and legalists can pursue whether there is a universal level of care or universal level of negligence - or must one weigh the individual merits of each case. Is there a universal consensus on standards of care? If so, is this consensus legally or morally based.

In searching for the fine line between the legal and moral position, complications and overlap are found in the more difficult-to-treat issues: i. e., the mentally retarded, the emotionally disturbed, cases of incest. "Who is the client" is very often the question that must be posed in order to arrive at basic principles.

This section includes papers from Canada, England, Israel, Scotland, and the United States. They offer an international flavor to the legal aspects of nursing, with the overlap between rights and responsibilities and treatment an inevitable reality.

Rights and Responsibilities

Human Rights in the Nurse-Patient Relationship

B. Bandman

1 Introduction

Nearly everywhere wo look, we find a growing number of assertions of rights in patients' and health professional relationships. These assertions of patients' and health professionals' rights present a basic issue: To what extent do patients and health professionals have rights? This issue may be illustrated by citing some examples: (a) Mary, a good nurse, claims the right to refuse to assist in performing abortions [1, 2]. (b) But then there is Florence, a 17-year-old, sexually active, single, impoverished parent. She claims a right to terminate her pregnancy with first trimester abortion, so she can care for her other three children.[1] The only available nurse is Mary. (c) Then there is Mary's friend, Tena, a nursing instructor, who believes that she has a right to recommend Laetrile to her cancer patient in place of conventional medicine.

The rights of nurses are not the only ones that generate dilemmas. (d) There is the case of Ben, a 2-day-old infant with trisomy 18. He has a right to be saved, according to his parents, even though 87% of infants with trisomy 18 die in the first year, and two other infants urgently need the only available respirator [4]. Perhaps even more controversial is (e) the case of 13-year-old Phillip, a mild child with Downs syndrome. His friends say he has a right to life-saving surgery despite his parents' refusal to consent.[2] (f) At the other end of the age spectrum is Ivan who is 82 and has a normal IQ. Nora, a nurse, says Ivan has a right to a prostatectomy despite his nephew's refusal to consent [6]. Does age or IQ make a difference between Phillip's and Ivan's right to live? Then there is the case of (g) Edward, a high-anxiety cardiac patient who has had several near-fatal heart attacks. He claims the right to refuse tranquilizers. Edward is, however, unknowingly given tranquilizers for life-saving reasons, thus setting aside his right to know the truth about what is being done to his body [7, p 135]. Or consider the case of Jane. (h) She requires a craniotomy. Jane's family members assert that she has a right to have her wishes honored and not be resuscitated in the event of respiratory failure. Her wishes are to donate her kidneys as a "gift of life" to a suitable recipient [8]. The question arises: If Nora or Mary is Jane's nurse, is she obligated to save Jane's life or facilitate her right to die? Does a patient's *wish* to die imply a *right* to die? Lastly consider (i) the case of Herbert, a depressed, suicidal man who believes he has a right to jump out of the 22nd-story hospital room; and if he has a right to die, then Mary, the nurse, has no right to restrain Herbert [7, p 136].

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[1] The format of these examples is adapted from Engelhardt [3]

[2] Adapted from George F. Will [5]

In response to these cases, there are four positions to be taken:

1. Patients and health professionals have no rights.
2. Patients and health professionals have option rights but no subsistence rights.
3. Patients and health professionals have limited option and subsistence rights, but in a pinch subsistence rights override option rights.
4. Patients and health professionals have unlimited option and subsistence rights.

I will try to show that the third position is more defensible than the others and that this position provides a basis for deciding whose rights in these cases are worth taking seriously. Several philosophical moves have recently been developed in defense of patients' and health professionals' rights.

2 Philosophical Moves

2.1 Quorum Feature

One philosophical move consists in applying the idea of "quorum features" to the question, "When does human life begin and end?" [9]. You know what a quorum at a meeting is. Usually a previously agreed minimal number of persons have to be present for there to be a meeting. So, one philosophical move consists in applying the idea of a quorum feature to the question, "When does human life begin and end?" A person who lacks the quorum or majority of essential features of an ordinary person, such as one who has multiple deformities or lacks consciousness or has trisomy 18, gives a reason to doubt the viability of such a person's life.

2.2 Tracing and Examining for Appropriate Metaphors and Models

A second, four-part move consists, first, in considering a viewpoint which purports to provide an answer to a question such as, "When does human life begin and end?" or "What is a person?" This move consists, second, in tracing that viewpoint to some deeply acknowledged metaphor or metaphors on which defense of its viewpoint depends philosophically. Third, one examines the metaphor to determine how it applies or breaks down in practical discourse. One may consider, fourth, whether supplementary or alternative metaphorical analogies aid in the defense of a given viewpoint.

In regard to a pregnant woman, for example, one may ask the metaphysical question, "Is she one being or two?" [10] To individuate at the moment of conception is to regard a woman and her fetus as two basically equal beings. This view generally regards a woman as a passive receptacle in whom life is implanted. Alternatively, a woman may be seen as a receptacle into which an item is inserted for the completion of a productive or creative process. On this essentially passive view, a woman does not create "the gift of life" within her, to cite St. Thomas Aquinas's insightful metaphor [11], but rather receives life. An opposing perspective, however, views a pregnant woman as a property or factory owner, one who may do with her own body, as with her property, as she pleases. On this view, a woman owns her body, which implies that she may do with it as she wishes. Each metaphor may be examined for its illumination as well as for its implied difficulties. Life, for example, is not always a gift, as the examples of the infant with trisomy 18 or the patient in need of a craniotomy amply show. On the other hand, human life is not quite like someone's property or factory, contrary to the claim of some writers that a mother makes a baby.

2.3 Biological/Biographical/Social/Cognitive Distinction

A third move by J. Rachels and W. Ruddick distinguishes biological or zoological life from a biographical life. A person who has hopes, projects, a past, joys, frustrations, a future with expectations and prospects - all of which presuppose consciousness - is said to have a life [10]. If you can make an omelet or tie a shoestring or plan a vacation or build a castle in the sand or drive a car or play a musical instrument or have a project, you're living a biographical life, not just a biological life, which Karen Ann Quinlan is leading.

Missing in the biological/biographical distinction is that one also has a shared social life with others. All sorts of evil or indifferent individuals have solitary projects that don't contribute to a socially worthwhile life. A socially worthwhile life also calls for appropriate recognition of, and training in, standards and skills of sustained intellectual judgment, a common understanding of the methods and results of cognitive disciplines, as well as appropriate regard for, and familiarity with, rules of evidential backing. The biological/social/cognitive distinctions rule against identifying someone as a person who has extreme physical or intellectual or social or psychological handicaps, such as trisomy 18, on the grounds that he is unlikely to have a humanly worthwhile life. These distinctions also support a woman's right to terminate an unwanted pregnancy on the ground that a woman in this predicament is unlikely to provide a worthwhile human life for yet another child. By implication, the biographical/social/cognitive distinction rationally counts against a nurse's right to refuse to assist in such abortions. Lastly, the cognitive requirement gives a reason against a nurse recommending Laetrile.

2.4.5 Examining the Meaning and Importance of Rights

A fourth philosophical move in defense of patients' and health professionals' limited rights consists in clarifying the meaning and importance of a key concept, such as the concept of rights. Rights have variously been defined as permissions, claims, powers, and entitlements. Each definition has defenders and opponents. Rights seem to be many faceted and too complicated to expect satisfactory one- or two-word definitions. We might instead look to some common features generally recognized as conditions of any right.

One condition of any right is freedom. To have a right based on freedom is to be accorded a sphere of autonomy or self-determination, to exercise one's rights as one chooses, and to be immune to the charge of wrongdoing. It is the area of one's life which, as Joel Feinberg aptly puts it, one is the "boss" [12]. Two writers refer to a right as a "fenced in" backyard where one may do as one wishes [13]. The right to be free, for patients and health professionals alike, includes the right to be treated rationally, which implies the right not to be coerced, brainwashed, lied to, deceived, unknowingly given drugs, or have one's body entered without the right holder's consent or permission.

Secondly, to have rights implies that other relevant persons have corresponding duties to comply with the terms and provisions of one's rights. If a client has a right to a vaccination, health professionals have a duty to administer it and are - in Aiken's and La Follette's terms - "on a leash" held by the right holder, which mandates their compliance [13]. As Feinberg puts it, "rights are necessarily the grounds of other people's duties" [14]. A third condition of any right is that rights purport to be consistent with rationally defensible principles of justice [15]. Rights thus imply freedom, duties, and justice.

3 Option Rights and Subsistence Rights

Among rights of an important kind based on freedom, duties, and justice are human rights. Human rights are the union of two kinds of rights: option rights and subsistence rights. Rights used to be regarded since around 1450 as rights to be free from interference or as negative rights. But in the late 1840s a distinctly different kind of right emerged: a right to receive social and economic assistance, sometimes called subsistence rights or positive rights. These rights have some strange and assorted sources, one in the development of the right to education and another in the right to health care. These rights developed in Germany and in the United States. From 1920 on, this second kind of right came from eastern and western socialist countries. The United Nations' Universal Declaration of Human Rights (1948) [16] expresses an accomodation between these two kinds of negative and positive rights. Articles 1-21 express traditional rights, such as the right to vote, to worship, to free speech, to a free press, and to free choice. These are sometimes called option rights or self-determination rights and, importantly, include the right to give informed consent. But Articles 22-27 of the United Nations' Universal Declaration of Human Rights express the right to receive social and economic resources, including food, clothing, shelter, health care, and education, at public expense.

Since we cannot live by freedom alone, to have rights of value is to have rights to needed resources as well. Human rights serve, in J. Nickel's terms, "as an independent standard of political criticism and justification" [17]. One may appeal to human rights - rights shared equally by all human beings - to annul, cancel, transcend, or override all rights that conflict with them. Human rights set standards for the critical evaluation and justification of social, educational, and health care practices. To have human rights provides an injunction that gives public notice that the burden is placed on all those who attempt to justify exceptions to, infringements upon, and abuses of commonly accepted standards.

A strength in appealing to human rights in health care, then, is that rights provide moral buffers against unjustified forms of interference, neglect, or deprivation by others. A client who has rights may give or withhold consent, and it is mandatory for other relevant persons, to comply with a client's rights. A nurse, such as Nurse Ratched in K. Kesey's One Flew Over the Cuckoo's Nest [18], has no right to coerce a patient, such as McMurphy, to take his pills.

A central issue in the ethics of nurse-patient relationships concerns the relation between negative and positive rights. Some writers identify rights with negative rights only, rights to be left alone, to choose, regardless of consequences, but not too much else. If a person is helpless, too bad for him or her. On this view, no one has a right to be given help. The single principle of one's right to decide what happens in and to one's body or to express one's belief that one owns one's body and one's beliefs seems to be the metaphorical analogy that covers one viewpoint concerning some of our remaining, more intransigent cases.

The view invoked in defense of one's right to control what happens in and to one's body and one's beliefs has recently been called the "will" or "choice" view of rights [19], an unduly stout form of antipaternalism. That view seems morally impoverished, for it fails to account for a person's incapacity to express option rights if a person is either too poor, too sick, too unenlightened, or too powerless to express autonomy or self-determination rights. There are cases in which a person does not know best and in which he or she needs help to make the wisest decision. In an important paper, Elsie Bandman cites an example of a would-be suicidal patient whom the nurse saves from death by preventing the patient from plunging out of a 22nd-story hospital window [20]. This does seem to provide a counterexample against identifying a client's right by doing whatever the client wants to do out of his or her own choice and not ever restraining the client.

There are limits, however, to one's autonomy. Identifying one's rights with one's will and desire exclusively is not the only way to decipher one's most vital rights. One may also connect one's rights to one's best interests. There are grounds of justified interference with one's liberty both for one's interest and for the good of others. One may be restrained from unknowingly harming oneself, such as taking medically inadvisable forms of treatment. One may also be counseled to take appropriate measures to prolong one's life, where the evidence on behalf of the viability of one's life warrants doing so.

Recently, D. N. MacCormick developed a distinction between a "will-based" view of rights, which emphasizes values associated with freedom, and rights of another kind, an interest-based view, which emphasizes benefits conferred equally on all persons, regardless of the capacity to exercise one's will [21]. The United Nations Universal Declaration of Human Rights shows that Articles 1-21 are oriented by a will-based view, whereas Articles 22-27, which include the right to a decent standard of living and the right to health care for everyone, are oriented by an interest-based view. Rights of this kind have a crucial bearing on deciding quality-of-life issues quite differently from deciding under the influence of the will-based view of rights.

To show how subsistence rights may have priority over option rights in crunch cases leads us to consider our remaining cases, one of which is about Edward, a high-anxiety cardiac patient. If one believes in the moral priority of preventing harm, a case may be made, it seems, showing that the health team is well within the bounds of respecting the fundamental interest-based rights of the patient, to withhold information from the patient. The right to live and not be seriously harmed, on an interest-based view of rights, is even more fundamental in a pinch than the right to remain free. If a wise nurse knows that there is still a viable and enjoyable life to be lived in which the patient who is prevented from harm or death could retrospectively after a time say, "Thank you for not listening to me when I wanted to refuse help," then we do not think such a nurse has wronged the patient. On the self-determination view, the nurse will be apt to perceive herself as the servant and instrument of the patient, willing dutifully to assist the patient and to take the client as his or her word. It may sometimes, however, be better for the nurse to perceive herself as a friend of the client, in Aristotle's sense, one who cares with intelligence and wise judgment. Ordinarily to deprive a person of rights is to do something wrong to that person. But that can't quite be said about a nurse who saves a would-be suidical person whose life is still viable. If a nurse saves a suicidal patient's life, refusing to help carry out the patient's wish of the moment, what will be our attitude? Would it be to condemn the nurse for refusing to pay attention to the patient's will? If the patient could conceivably be grateful afterwards for having been saved, we do not think such a nurse could seriously be said to have wronged the patient.[3] One could thus set aside a patient's will-based rights by considering a person's own, more fundamental, deep, interest-based rights that are preemptive, that, in a manner of speaking, shine over all else.

We come now to perhaps the most difficult case, that of the craniotomy patient. Here the patient asks the nurse not to save her life under certain conditions. To comply with this patient's right to die requires the nurse, on one view, to commit murder. But is it murder? In one sense, to destroy or fail to save a human life is a serious wrong, but not if that life is no longer a gift to that person. A human life ceases to be a gift if it no longer has humanly worthwhile prospects. We know when we have the considered judgment not only of the afflicted but the judgment of all those who seriously attend the plight of those whose lives are no longer gifts but unbearably painful burdens filled with suffering, anguish, and torture. In hopelessly terminal cases, if we consult the patient's most fundamental interests as friends (in Aristotle's sense), we might then recognize that since their life prospects are hopeless, we, were we in our friend's place, would regard a further prolongation of a human life as no longer perceivable as a gift. To be a friend in that type of hopeless case is to help, even if it means ending our friend's life, as Freud's physician was willing to do. If a nurse does not resuscitate a craniotomy patient who asked not to be resuscitated, I think that under certain retrospectively verifiable circumstances, we would not think it wrong.

The kind of rights this appeal might require is not the older, political liberty or option rights view, which says, "Don't interfere," but the newer one which says, "Help me; assist me." A view of rights which addresses a client's or nurse's vital, rational interests seems the more adequate at such a time. These deeper subsistance rights to live well are most closely associated with social and economic justice and provide the conditions for the subsequent effective exercise of self-determination rights.

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[3] We may call this a retrospective analysis of patients' and nurses' rights. Those who don't object to counterfactual conditionals will find this analysis congenial

4 Conclusion

In this paper, I tried to show that patients and health professionals have limited human rights, that such rights are the union of option and subsistence rights, and that, in a pinch, subsistence rights are preemptive[4] or exclusionary[5] in that such rights exclude and override all other value considerations. To show whose rights to take seriously in these cases, several recent philosophical moves were described and discussed: the quorum feature notion, tracing viewpoints to their metaphors and examining the extent of their applications and the biological/biographical/social/cognitive distinction.

Rights are important to all people. Rights provide people with dignity and self-esteem, as well as sustenance and fulfillment. In the constellation of values enriched by human rights, freedom to choose is an important part of the rights of patients and health professionals, but as D. N. MacCormick points out, it is not the only right. The right to be helped to live a decent and fulfilling human life [18] is also good; and in a pinch, the defense of this other right may matter even more than having a choice.

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Whats Wrong About Rights

M. Levine

The rights of the individual are perceived as natural, self-evident, and inalienable - necessary fulfillments of human needs which are universally shared by all persons. They are defined as the guaranteed privilege of access to the individual's fair share of the community's wealth. Rights make certain the accessibility of adequate food, shelter, health care, schooling, and the means to procure the rewards of success: the symbols and gadgets of affluence. Rights also include intangible prizes - the freedom of speech and worship and assembly, due process, protection of one's person from all threats, and reasonable assurance that everyone will be treated with dignity and respect.

The certainty of each person's selfhood is translated into the language of rights. And still, there is no certainly that every person will receive his portion. The faithful dependence on the Bill of Rights in the United States does not exclude the fact that there is a continuing struggle to define individual rights in the face of repeated challenge. The government is enjoined against interfering with the freedom to speak, but time and again the right to speak freely must be reasserted, often in the courts. The unhappy fact is that "rights" are not God-given at all, but rather the product of very imperfect, human determinations. Rights can be given and they can be taken away. Laws can be written and they can be repealed[1] There is confusion between the legal nature of rights and the ethical imperatives of health care. Legal and ethical are not necessarily equivalent, and declaring them so does not serve the best interests of patient or practitioner.

The most grotesque example of the consequences of such an error in discrimination was the "lawful compulsion"[2] of the Jews of the Holocaust to submit to so-called medical experimentation by German physicians and nurses [2]. The Jews were legalized victims because the Nuremberg Laws of 1935 had made them non-persons. Stripped of all rights, including sovereignty over their own bodies, they could be used as laboratory animals without the least challenge to the conscience of the so-called experimenters. To this outrage another was added: the "doctor trials" at Nuremberg which legitimized so-called medical excesses, as if the performance of those vile and obscene deeds had any relevance whatsoever to medicine.

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[1] "The rights persons have, hold or possess have been *given* or *granted* by a legal system .... Rights conferred ... are not ... fixed or final ... one can lose one's rights. Rights are revokable (sic)." See Bandman and Bandman [1]

[2] The word "lawful" lends awful legitimacy to these criminal events. Many authors have reduced the facts to banality. See Beauchamp and Walters [3] "Since the Nuremberg Trials, no aspect of human experimentation has received greater attention than the issue of consent. In the Nuremberg code itself consent is discussed in the first and longest article."; Rutstein [4] "The human experiments performed by the Nazis during world war II horrified the world because they were designed to answer unethical questions"; McCormick [5] "... there has been a gradual move from the absolution represented in the Nuremberg code to the acceptance of proxy consent possibly because the Nuremberg code is viewed as containing, to some extent, elements of a reaction to the Nazi experiments"

It is difficult to understand why the physicians who invented the most exquisite tortures on helpless persons were accorded the dignity of a trial based on the supposition that they had merely performed bad experiments. Indeed, the most immoral aspect of the Nuremberg doctor trials was the serious introduction of debate by defense attorneys (carefully guarding the rights of their clients) that sometimes individuals may be sacrificed against their will for the good of the state; that military service was no different than involuntary assignment to medical experiments; or, indeed, that the historical evidence proved that protocols of individual rights were frequently trampled by medical experimenters in other times and places and abundantly reported in the literature [2, p 320].

Even though the court found most of the defendants guilty, the larger share of guilt belongs to the society that condoned the separate treatment of physicians as if they had any-claim to scientific legitimacy. There has been a continuing reinforcement of that disgraceful decision by the frequent citation of the Nuremberg doctor trials as the basis for present-day rules of informed consent. Such an interpretation of those events serves only to reinforce them as rational and acceptable - and they were neither. Nor is there any comfort in the contention of many writers in bioethics, to quote one, that "... no human action before or since parallels (the Nazi) degree of evil" [6].[3] To point to the Nazis simply as examples of the depth of the depravity to which man might sink is to bear false witness against the Jewish people and their history, because the depravity so methodically demonstrated by the Germans was taught to them by generations of haters, defilers, and murderers of Jews. They had excellent models of bestiality, and they learned their lessons well.

It is pitiful that one must cite Nazi excesses in the name of medical experiment to raise, as one author says, "The consciousness of the public about what human beings are capable of doing to each other in the name of medical science" [6]. It is naive and ignorant to invoke those events in order to receive the lesson of man's inhumanity to man, and none are served by reciting the litany of the misguided research of others - which was, in fact, misguided but not malicious - as a means of softening the full impact of the abominations performed by Nazi doctors and Nazi nurses on Jewish people. We owe no debt to the Nazi doctors. They did not teach us of evil merely, nor did they teach us, through their awful example, of the proper protocol for human experimentation and treatment.[4] They taught us only how easily a silent world could turn its back on their victims, pretending to this day that there was a medical excuse for their deeds and thereby enlarging the awful silence.[5]

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[3] See also vaux [7] "The most important ethical insight from Neuremberg (sic) is the reminder it gives to the potential evil in man. The experience serves as a constant refutation of the myth of inevitable progress" and Davis and Aroskar [8] "The single most important ethical insight (of the Nuremberg code) is that it reminds us of the potential evil in human beings and serves to constantly refute the myth of inevitable progress"

[4] Even so prestigious and germinal a work as Paul Ramsey's [9] assumes without questioning, the validity of "Nazi experiments" as a justifiable basis for the "Nuremberg Code". Attributing initial authorship to Dr. Leo Alexander, he regrets only that the Tribunal excluded Dr. Alexander's "proxy clause". "The Nazis simply were not doing beneficial research," writes Ramsey

[5] The apathy, indifference, and silence of the nations of the world has become the subject of a growing literature. One of the earlier works was Arthur Morse [10]. More recently Walter Lacquer [11]. The revisionists who now purport to "prove" that the events of the Holocaust are Jewish fantasies stand on the indifference of the generation of silent witnesses

If we had no instruction but this from which to create the rules of behavior that regulate the joining of physician and nurse to the patient in shared purpose, we should be gravely hampered in establishing a structure of health care. Surely the tenets of ethical conduct are not produced by the most evil of men, but rather are the consequences of kindness and caring, as much natural attributes as the desire to cause harm and suffering. There is a potential for evil in man, but there is also a potential for good. It is one thing to base on ethical position on the only proper defense of the ancient, but primitive, physician, who, using the rule to "do no harm," avoided the consequence of his own ignorance. But it is no longer sufficient to "do no harm."

Now we posses the instruments, knowledge, and technologies for controlled, successful interventions and "harm" has become a potential consequence of both omission and commission [12].

The basis of relationship between practitioner and patient must come from a fundamental source of decency and mutual respect, a decency founded on the existence of an abiding trust in the good will of each for the other. Individual rights have validity only in context because through such rules the community brings justice and order into the lives of all of its members. Learning to venerate the rights of others comes from caring. In Gaylin's words:

> ... the protective, parental, tender aspects of loving- ... a part of relationship among peers, child to parent, friend to friend, lover to lover ... The linkages between being cared for and caring for others are crucial ... [13, p 33]

There is no sense to health care which ignores that "linkage." But the inviolability of individual rights has become the canon of modern health practice. In defense of the rights of individuals, elaborate systems of monitoring and control have become commonplace. The protection of rights has evolved into a complex bureaucratic machine, living a life of its own. Dedicated to the proposition that evil organizes relationships, it is as if the Nazi doctors stood at our side, directing us to distrust our own best instincts. When defense of rights becomes the voice of hostile and aggressive intentions, then the ghosts of those monsters must celebrate, indeed. And carried to its ultimate excesses, "rights" may become the weapon with which decency itself is destroyed.

What motives are served in the warning Glasser addresses to us to "... respond to the claims of service professionals as if they were cops" [13, p 124]. Both the social worker and the policeman serve "important social ends," he says, but "both are dangerous. Both will violate rights in the course of their jobs if they think it is important enough, *and therefore that is a decision that cannot be left to them.*" Cops and social workers, says Glasser, are "... not the guardians of their client's liberty." Exactly so. The service professional is only the guardian of the patient's dependent need in every instance where an individual has presented himself for help. It may, in fact, be more accurate to say that it is becoming necessary to guard the patient from interference with appropriate care instigated by his lawyer.

In a way never intended, the very rules which were designed to safeguard and protect the interests of the patient now pose a threat which increasingly thwarts the care process. Rules restricting the behavior of the physician and the nurse affect therapeutic protocols as well as research designs. Health professionals know full well that the patient does not discard his rights with his clothes on admission. But he also has not entered the caring relationship to confront and confound the service professional. He has come to fight only that which has disabled and discomfited him, anticipating justly that he will be met by physician and nurse in a spirit of concern and service. Nurse and patient cannot be adversaries and no outside source serves either one by creating an adversarial confrontation. Glasser has called the patient a "Prisoner of Benevolence" but he is prisoner only to the pathophysiology that requires the intervention of the nurse. Only the awful emphasis on evil intentions could have turned the two words "doing good" into a nasty threat [13].

The real world is often cruel and unjust. But how is that changed when the desire to reach out to each other requires first that we analyze each act to be certain it conforms to the statutes? Yet that has often been the effect of the excessive movement of legal restraint in the therapeutic relationship. Is the patient really served best by "defensive medicine"? Must the lawyer's shadow fall constantly on the nurse's interaction with the patient? Have the Nazis thought us only to be suspicious of each other, even in those professional roles which are dedicated to the service of the sick and disadvantaged?

The individual practitioner is permitted the freedom of his art and science within the social restrictions created in the laws that license and regulate it. Society creates the ground rules for practice, but the professional demonstrates his competence - even his minimal competence - as the price for the performance of his craft. Professional practice acts should be the product of a trusting relationship between the practitioner and the community he serves. Thus a practice law that is the careful result of collaboration between the lawmaker and the professional creates the limits on the rights of the practitioner and thus guards the welfare of the community. Incompetence cannot be tolerated, nor, indeed, any act which compromises the law. If the licensed practitioner cannot be trusted to fulfill his obligation under the law, he should not be licensed or his license should be removed. Such laws exist, some less perfect than others. But protecting the rights of the patients does not come from a failure to properly restrict the service professional. It is rather a failure to enforce the laws already established. While professional disciplines have the responsibility to police themselves and demand not minimal, but optimal, performance, the enforcement of the law is as much the community's concern as it is that of the profession. The imperfect way in which regulatory laws are enforced suggests that passing new restrictive laws will hardly improve the protection of the patient's rights. Beyond that, the individual who is licensed to practice does not become immune from the same restrictive laws that all citizens must obey, nor does he relinquish his share of protection under the laws that sustain his well-being. Clearly the recent statements that purport to guarantee "rights" to selected populations - such as the American Hospital Association's "Patient's Bill of Rights" - were redundant statements reflecting legal restraints on practice already well established.[6]

And the lesson of Nuremberg tells us that when the laws are changed, however arbitrarily, no degree of committment to human dignity will protect the victimized populations. Finally the exercise of respect depends on the individuals who meet each other at a mutual level of concern. Historically, nursing traces its lines from the

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[6] Many authors have directed attention to the redundancy of this document [14]

nurturing process, that relationship which Gaylin called "caring." Nursing has been constantly renewed by individuals - men and women - who sought for themselves the caring role fostered by their belief in human service. The formal education of the nurse provides the individual with the instruments and knowledge of caring, but the way it is used by each person depends upon his personal values. Certainly we are long past the naïveté of that time when the "good nurse" was described as a "good person" and that sufficed for the moral imperatives of caring [15]. Now nurses are exploring their ethical beliefs, learning to challenge each other, and examining in discourse the motivations, dedications, and decisions which have been the substance of practice of individual nurses.

But the dialogue has barely begun. Preoccupation with ethical dilemmas has served only to emphasize how intensely personal the preferences of individual nurses are, coming not from the convictions of the professional role, but rather from a stirring of unexamined individual belief. The dilemmas of health care will not be resolved by professional practitioners alone, but in concert with all of those in the community whose interests are challenged. But the nature of nursing care is the proper concern of professional nursing, and the examination of its ethical nature must be seriously addressed.

Perhaps the most urgent moral issues in nursing occur in the daily interaction between nurse and patient in whatever environment their meeting takes place [16]. It is reflected in the common courtesies exchanged between the patient and the nurse: the respect for privacy and person, the patience and forbearance of the care giver with the irritability and discomfiture of the care recipient. It mirrors the caution and concern of the nurse who has not only prepared well the ministration or treatment to be performed, but has prepared the patient equally well so that he understands the intent and participates as a full partner with veto privileges. It is the ready use of compassion applied with equal fullness for all persons, but especially those who disappoint the nurse by intransigence or a life-style that suggests he is his own victim. It is the dedication to truth-telling, recognizing the dignity of every individual and all who care about him: family, friends, community. And often it is the ordinary, mundane, casual exchanges when the patient and the nurse, trusting each other, pose no threat to the rights each possesses because they are sharing a human moment that will enlarge the good in each of them.

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Medical Care: The Problem of Autonomy

U. Lowental

People sacrifice some of their autonomy by becoming patients. Therapist-patient relations may involve a greater or a lesser degree of such intrusion. Therapy may be like a *mutual participation,* with patients consulting us only occasionally, as is the case between adults. At times it may be a *guidance-cooperation* with patients who continue to excercise some judgment, although required to comply, as it is with adolescents. Often it is more of the *activity-passivity* type and patients are treated as if they were children.

A patient's best interest require that we disregard his self-determination. Thus, we shall withhold any water from the lips of the thirsty, dehydrated accident victim who is wheeled in for surgery, and we must perform a painful change of dressings or a cystoscopy or a lumbar puncture, despite patients' painful outcries or their pleading for mercy.

Patients are denied the right to be impatient, and they are hardly granted the autonomous choice whether to give or to withhold their consent to treatment. Minors, mentally sick, or comatose or dying patients are usually overruled. Medical care involves additional, insolvable dilemmas. For instance, what should be done when a "terminal" patient has to be removed from a bed in the intensive care unit to make room for a recently injured, comatose young driver? Or: do patients really have the autonomous right to sign a "living will", requiring, for example, that all treatment be stopped in case of a bronchogenic carcinoma or bilateral inoculation?

Do we always have the advantage of greater objectivity to justify our *"medical paternalism,"* our withholding the truth from patients and disregarding their autonomy in many other respects, too?

The issue is quite complex, since autonomy is, in fact, *relative.* Even the frank, recordable, and measurable freedom from external control is relative, as we have seen more than once when a wounded prisoner-of-war was returned from captivity to his homeland hospital. They greet their recovered freedom, even though they may now be chained and suspended in a plaster cast, with tension devices and infusions.

Internal forces, like drives or psychological recoils, affect the autonomy to a similar, or even greater, extent, as is known to everybody. Beyond this, we have the unalterable *genetic* endowment: one cannot decide upon one's height, one's intelligence quotient, factor VIII deficiency in hemophilia, or the extra chromosome in Down's syndrome (mongolism). There seem to be no *real* autonomy from one's *self* - or from fate. The membership in a certain minority group, or the winning of a million dollar prize; these affect one's life and health but are certainly the result of *force majeure.*

The call to observe autonomous decision making and to respect each individual's tradition seems almost axiomatic. With geriatric patients, for example, therapeutic compliance is enhanced by a careful attention to their life-style and habits. Demands which ignore these may appear to them as violation of their autonomous, well-established identity, creating a distress even worse than the original disease for which they had come for treatment.

On the other hand, many patients feel uptight, helpless, and depressed. Emotionally, they regress into an infantile dependency, so that quite often they seek no autonomy, but - on the contrary - they welcome any opportunity to delegate all decisions to the doctor or the nurse. They want *help* rather than autonomy, hence our excessive regard for the latter might actually go *counter* to their free choice! It seems we all need a true skill of empathy to handle such complex situations.

What about the autonomy of the therapeutic team? The institutional hierarchy with its division of roles and responsibilities leaves only a narrow margin of autonomy to each nurse or physician. It reminds me of the Orthodox Jews' code of behavior, the *Shulchan-Aruch,* which covers and guides us everywhere. Medical ethics leave very little leeway even in a solitary private practice, since many decisions must choose the lesser evil out of several equally justified alternatives.

Furthermore, each one of us is *biased* in his or her evaluation of patients. One feels a greater empathy for old patients or for the very young. Some prefer patients of their own ethnocultural background or only those who display a genuine agony. There is the bias of one's medical *Weltanschauung:* Do I usually administer only the minimal necessary treatment in order to foster patients' autonomous striving for health, or do I use each opportunity to interfere with a patient's bad habits, according to the principles of preventive and holistic medicine?

In conclusion, we health professionals find autonomy to be a complex, dynamic parameter of therapeutic transactions. Many of its multiple levels are concealed, preventing a direct observation and requiring our inferential reasoning and a careful, self-conscientious scrutiny. Paradoxically, some of these aspects must be dealt with in an illogical, intuitive fashion. Thus, patients are encouraged to regain a full, autonomous health. If we respect their autonomy, we may assist them in another direction too, as it was pictured by Emily Dickinson:

> The heart asks pleasure first,
> and then excuse from pain,
> and then those little anodynes
> that deaden suffering.
>
> And then to go to sleep,
> and then if it should be
> the will of its Inquisitor
> the liberty to die [1].

Rights and Responsibilities of Nurses as the Basis for Their Contracts with Society, with Patients, and with Colleagues

M. J. Flaherty

1 Definition of Nursing

Whenever nurses meet, they express concern about the quality and quantity of their professional practice. One always tries to define nursing. Florence Nightingale was the first (and perhaps the last!) nurse to believe that she had done this. Since her time, many definitions of nursing have been proposed, but most lend clarification to what nurses *do* rather than what nursing *is.*

One Canadian nurse works with a statement about nursing that constitutes a definition of it. Doctor Marian McGee, Dean of the Faculty of Nursing at the University of Ottawa, describes nursing as a process of nurse-patient interaction that stems from the assessment of a patient's needs and levels of functioning and that is designed to optimize the patient's adaptability through modification and/or reinforcement of the environment, modification and/or reinforcement of behavior, and biological care and maintenance. The process can be accomplished through the use of nursing care strategies in appropriate measure (M. McGee 1975, personal communication). This definition says *what nursing is* and *what nurses do.* It incorporates the notion that nursing practice focuses on the promotion of optimal health for individuals and families. Health is a manifestation of the competence with which individuals and families function. States of health vary according to the efficiency and effectiveness with which individuals and families interact with their environments. Hence, health states are measures of functional competence. It follows that if the aim of nursing is to promote functional competence, nurses in various settings must be well versed in the knowledges, the techniques, and the conceptual and theoretical rationales that underlie nursing practice. One might wonder whether nurses are qualified for such work.

2 Professional Status of Nursing

Nurses of the 1980s have declared that they are professional and that they want to embrace the privileges and responsibilities of professional status. Like other health care workers, nurses are faced daily with complex issues and are called upon to make far-reaching decisions. Members of our society believe that professional nurses possess certain characteristics that have prepared them to exercise their proper roles as citizens and as health care professionals [1].

The first of these characteristics is education, both general and specific. General education equips nurses to think and reason with accuracy and to appreciate the world in which they live and work; specific education gives them a theoretical framework for their practice. Nursing education programs are designed to meet the needs of students in the light of the professional demands that are expected to be placed upon them in the health field.

A second characteristic of the professional nurse is acceptance of a code of ethics. The high value that nurses place on the worth and dignity of human beings directs them in their practice. As certain elements and characteristics of society change and as roles of people, including professionals, are altered, ethical codes may be subject to modification. The basic quality demanded by a code of ethics is *integrity;* that means "doing what one believes to be right, regardless of the cost" (P. Maloney 1962, personal communication). Belief in something implies that a person has given careful thought to the information at his or her disposal and has arrived at a logical conclusion. Beliefs may be modified in the light of new evidence and the nurse with *integrity* has the courage to change his or her mind. However, as Marcus Aurelius has warned us in *The Meditations;* "But this change of opinion must proceed only from a certain persuasion, as of what is just or of common advantage, and the like, not because it appears pleasant or brings reputation" [2].

A third characteristic of nurses is dedication to the ideal of master craftsmanship in their work. In *The Metaphysics,* Aristotle noted that "the master craftsmen are superior in wisdom, not because they can do things, but because they possess a theory and know the causes" [3]. True mastery of nursing is not something that is acquired suddenly, rather, it is an ongoing process that demands of nurses that they strive constantly to add to personal knowledge, to perfect professional skills, and to enlarge the body of knowledge for the discipline. Florence Nightingale is said to have stated that "Nursing is a progressive art in which to stand still is to have gone back. ... Progress can never end but with a nurse's life" [4]. The hallmark of a master craftsman in nursing is an enquiring mind and a commitment to continuous learning.

A fourth characteristic of professional nurses is informed membership and involvement in the organized profession. Nurses who are intellectually self-employed think and speak for themselves and act according to their own decisions rather than according to what someone else has told them to do. Nurses with enquiring minds know what is going on in the profession and are involved in the development of new patterns. They will not tolerate the absolutism that could result if, as members of a "tired democracy", they fail to participate.

The final characteristic of professional nurses, subsuming the other four, is accountability or the taking of responsibility for one's own behavior. Nurses do not blame others for what is done or not done in the profession and in the society in which they live and work. Rather, they participate in decision making and live with the decisions. They accept the fact that, over time, they will experience both failures and successes but they believe that if they act responsibly, their successes will outnumber by far their failures. These nurses strive constantly to practice in a diligent, reasonable, and justifiable manner; they document their rationales; and they are willing to subject their practice to the scrutiny of their peers. Feeling no obligation to shoulder the burden of omniscience, they develop and apply strategies to deal with the almost instant obsolescence of knowledge and professional practice and achieve Dag Hammarskjold's "Maturity: that means among other things - not to hide one's strength out of fear and, consequently, live below one's best" [5]. The ethical nurse's "best" involves exercise of professional practice, through application of the nursing process, at the highest level of which that nurse is capable.

3 Standards of Nursing Practice

When persons qualify, apply for, and accept registration as nurses, they accept the commitment to exercise generally accepted standards of nursing practice in all situations in which they agree to function as registered nurses. Statutory or registering bodies for nurses must either develop standards of practice for the performance of nursing services by their registrants in their jurisdiction [6] or endorse a previously formulated set of standards [7]. This is in line with the responsibility of the statutory bodies to protect the public by ensuring that those persons who are registered as nurses are qualified to be so registered. It is through the establishment, maintenance, and ongoing development of standards of nursing practice that the registering bodies define the scope and nature of nursing practice, regulate the practice of the profession, and discipline or investigate registered nurses about whom there is concern. The license to practice nursing does not include a permission to practice poorly; it presupposes an obligation to practice well. For nurses, registration involves the formation of a number of contracts - with society, with the employing institution, with patients, with patients's families, with physicians, with other nurses, with health professionals in other disciplines, with students, and with other workers within the health care enterprise. All of these relationships are crucial to the day-to-day conduct of the work place and to the day-to-day practice of nurses.

4 Nurses' Contracts

The authority for nursing is based on a social contract under which society grants to the profession authority over its own functions, together with significant autonomy in the conduct of its own affairs. In return, the profession is expected to behave responsibly in accordance with the public trust. Since public and private health care institutions offer services that are defined both by legislation and by the policies of the institutions, the public has a right to expect that when these services include care rendered by registered nurses, conditions will be provided under which generally accepted standards of nursing practice can be met and indeed that such standards will be met. This constitutes the honoring of the contract that nurses make with the institutions. These conditions include the necessary staff and structures to make possible effective use of the nursing process, collaboration, coordination, and communication among all members of the health care team, behavior that is consistent with relevant legislation, with appropriate codes of ethics, and with the policies and practices of the agency, the maintenance of competence relative to current practice, and the acceptance of responsibility for professional behavior. Where nursing care institutions do not provide such resources, they are not fulfilling their legal, ethical, and social responsibilities to provide health and/or illness care given by nurses and other health professionals. They are failing to fulfill their commitments to society *individually* in terms of the recipients of care and in terms of the health care professionals and *collectively* as part of the public trust.

Because nurses are involved with significant personal concerns of other human beings, the foundation, form, and balance of values within the nurse-patient relationship are of great importance. Nurses view patients in their wholeness, in their completeness as human beings - body, mind, and spirit. The relationship is dynamic and may show the characteristics of all or any of these types: child and parent, client and counselor, teacher and student, friend and friend, colleague and colleague, and so forth through a wide range of possibilities [8]. This requires of nurses attention to significant moral considerations, such as the individual's rights of self-determination and bodily integrity. It is a complex relationship.

The function of nursing necessarily requires knowledge of the family as well as of the patient. This is true particularly when the patient and/or family are caught in the intricacies of a health problem that taxes their human relationships and coping capacities.

Nurse-family relationships call for partnerships as a central means for the solution of problems - keeping in mind the primacy of the nurse-patient relationship, the sharing of power, and the examination of conflicting views and the continuation of communication despite differences in expectations. It is a taxing relationship as nurses help families to cope in their own ways [9].

Nurses and physicians have inherited rather different basic images from history and these images persist in many areas today with little appreciation by each group for the other. Although they are supposed to be working on teams, often teamwork is absent and cooperation is lacking as the "guest practitioner" physicians wield a great deal of power over the nurses, who are regular employees of the institution. This leads to tension and lack of mutual respect [10].

The context in which nursing practice takes place plays an important role in the determination of the nature of nursing practice and hence of nursing care. Nurses are employed today by many kinds of institutions, the scope and complexity of which vary from the corporate bureaucracy that may be seen in a large multiservice hospital to the two- or three-person community clinic or physician's office. Between these two extremes are large numbers and types of health-related organizations in various areas and settings. Whatever the particular employing agency, it is essential that the nurse employee understand fully the nature, purpose, and obligations of the employing agency in order to understand the obligations, rights, and responsibilities of the nurse as employee. The trustees of health care agencies are held morally and legally responsible for everything that goes on in the institution, including the activities of all professionals who work in it. This corporate responsibility for the quality of care means that the agency can expect accountability and competence from all professionals in the agency [11].

Nurses, as members of a profession, have obligations to each other to work together to promote and foster high ideals in themselves and in their colleagues. People need to trust nurses, and to maintain this trust, nurses must trust and rely on one another. To do this, they must care for each other, by helping, teaching, and supporting each other, in the effort to realize nursing's commitments to society [12].

5 The Realities of Health Care Practice

The reality of today is that in health care agencies, there are tensions that lead to conflict. Inflation and fiscal constraints are facts of life today that push nurse managers to promote cost containment in the face of professional desires to maintain high quality of service and personal needs to protect their own standards of living [13]. Thus are nurses, at all levels, pulled to serve more than one master. As they attempt to choose among them, their orientations to their discipline and/or to their employing institutions may be disrupted [14].

Because registered nurses, by the very nature of their profession, are required to exercise judgment in the carrying out of their duties, there may be instances in which the institutional goals or directives seem to be at odds with nurses' professional judgments. However, just because a nurse is a professional with the capacity for judgment, he or she does not cease to have certain responsibilities, as an employee, to the employer. In most collective agreements, for example, it is recognized explicitly that there are institutional goals and that an employer is not required to shut down his institution during discussion of a difference of opinion. Attempts are made by nurse managers in health care situations to operate the institution in the interests of both parties to the dispute.

In a health care agency, however, there is a third set of interests that are paramount to both employers and employees; they are those of the patients or consumers of the health care delivered by the agency and its employees. For example, what happens to the patient when a hospital unit has too many acutely ill patients for the too few nurses who are assigned to the unit? That situation may occur when the administration of the hospital realizes that in order to stay within its budget, it must cut nursing staff. How can the agency provide health care that is appropriate and that includes *skilled nursing care* when there are too few nurses to provide *any kind* of nursing care, let alone *skilled* nursing care? All too often, the nurses in the situation have little or no voice in the determination of work loads.

How are the patient's interests protected when nurses in a situation believe that a patient has not given a fully informed consent to a procedure such as surgery? In a situation reported by a nurse who spoke from the floor at the International Congress on Criticial Care Medicine in Washington, D.C., during the month of June 1981, that nurse, having reported her concerns to both medical practitioners and to her superiors in nursing, and who was told that since a consent form had been signed by the patient, she should prepare the patient for surgery, refused to do so on the grounds that she believed the patient did not realize the nature and scope of the surgery. The nurse was disciplined by the agency and failed to win the support of her registering body. She believed that had she prepared the patient for surgery and taken her to the operating room, she would have been in contravention of the standards of nursing practice that included patient advocacy, and for which she was accountable.

What happens to the interests of the patients if nurses are told to carry out physicians' orders about which they have concern? Very often nurses are told simply to obey the order involved and that the physician will accept responsibility for the nurses' actions. Responsible registered nurses know that since they are always accountable for their own behavior, they share responsibility and guilt in the carrying out of an inappropriate order. In Canada, a number of the nursing statutes are explicit in the requirement that nurses question directives, policies, or practices about which they have concern. In spite of this, a great many nurses today believe that they are able to be directed by other health care professionals. Although this may not be as great a problem in Canada as it is in some countries, even there nurses often find themselves in situations in which they have limited authority, and when they attempt to exercise their broad ethical and legal responsibilities to and for patients, they feel powerless, excluded, and dependent if there is lack of nurse/physician collaboration and cooperation. Frequently, nurses are accused of being defensive when they insist that *nurses* be responsible for *nursing,* even though nurses' responsibility for their own behavior and for the regulation of their own profession is explicit in many nursing statutes. The nurse of the 1980s is responsible for professional judgment at two levels:

1. At that of a professional who influences and promotes change in health care policies in national, provincial, state, and local domains and who has input to policy decisions and to the establishment of standards in the profession at large and in the employing institution and
2. At the level of an individual practitioner - who may be a clinician, an administrator, a teacher, or a researcher - who is responsible for the quality of care provided for individuals, families, or groups.

Nurses' attempts to exert leadership in these areas for which they are accountable are met often with opposition from physicians, some of whom perceive nurses to be encroaching on their "professional territory", and some of whom reject and may even try to block the attempts of nurses to move beyond the "caretaker" role and to enter the traditionally physician-oriented "healer role" that has been directed toward the tasks that are necessary to restore an individual to a functional status. This goal, as carried out usually in a specialized health setting, has evolved into the traditionally masculine and medical role.

Some blurring of roles and overlapping of responsibilities and areas of function can be expected in situations where two professions such as medicine and nursing have the same clients and the same type of interests in those clients, that is, the promotion of the well-being of individuals, families, and communities. The practice entailed in such promotion necessarily involves intervention in the lives of others. Hence, it has an ethical component, whether the practice is direct patient care, the teaching of those who will enter the profession or who will increase their competence in it, and/or the advancement of the theoretical aspects of the profession through research involving individuals or groups. Ethical decisions that are based on values are made by these health care professionals. Their ability to fulfill their ethical responsibilities depends on the professional contexts in which nurses and physicians work: appropriate professional preparation, suitable conditions for the exercise of professional practice, social respect for the professional as a decision maker, and social recognition of professional expertise [15].

The ethical judgments made by nurses and physicians flow from personal conscience and include a weighing of alternatives - what *could* be done - and the making of decisions - what *should* be done. As alternatives are weighed, past experience, possible consequences, and personal strengths and weaknesses come into play. Once the decision is made, personal inventiveness and strength of will are important in the implementation of the action that flows from the decision [15]. Although nurses and physicians pride themselves on their sensitivity to cultural and family factors that influence patients' problems, what do they do when the patients' wishes and values are in sharp conflict with those of the health professionals?

Whose values should take priority? If the health professionals' values take precedence, how does this affect the patient-professional relationship? On the other hand, if a patient's values take precedence, how does this affect the professionals' responsibilities to practice their profession and to care for the patient in the way that they believe is best for the patient [16]? How can health professionals make decisions that may be advantageous to their patients but a burden or a strain on society as a whole? Should continuing and complex health care be provided for patients whose conditions are self-induced?

Although it is stylish today for health care professionals to talk about working with patients as partners in the health care enterprise, patients have reported that they do not feel they are part of such an arrangement. Instead, they feel like numbers "being shuttled about" in the absence of psychological preparation for certain experiences, such as intensive care units, where the prevalence of electronic monitoring equipment is in sharp contrast with the lack of human warmth and compassion. Some patients have felt like "intruders" and they have experienced, from health professionals, little or no inspiration to make the special effort that is necessary to get well [17].

It is obvious that nurses and physicians share the "commitment not just to individual life but to the institution of life" [17]. If they and their professional associations are concerned solely with professional and territorial questions, their professions and the members could become and remain insulated from this control role, with the result that they would "trail happily after illness while ignoring ... [their] obligation to help humanize society and make it safe and fit for human beings" [17]. This requires not only expertise in professional practice, but also knowledge about ethics or understanding of ethical systems or moral reasoning and "good moral reflexes" [18]. These can be refined through the help in the clarification of ethical values and issues that is available from colleagues who understand the situations involved. Physicians and nurses who demonstrate what they profess, that is, participatory membership on a health care team, practice as *colleagues* - with respect for each other's expertise and contributions, consideration of each other's points of view in their decision making, and genuine collaboration in the common goal of the promotion of functional competence in the recipients of health care. Such practitioners feel no obligation to shoulder the burden of blind obedience to prescribed procedures and the maintenance of traditional values. Like Socrates, they believe that "the unexamined life is not worth living." Hence, they assert themselves and challenge existing beliefs and practices if what they see in the situations in which they find themselves, including their own behavior, is not consistent with the standards of practice for which they stand accountable.

6 Cooperative Health Care Practice

Health care delivery should not be a power struggle - a struggle between diverse vested interests with shifting alliances, depending on the issue and the disparate interests therein. In a democracy, most people still identify individual rights and freedom as extremely important, if not inviolable. However, group efforts and participation of many people are seen as useful approaches to the solution of common problems. Public accountability by health care institutions has led more and more people to question programs and expenditures as they never did before. They are demanding moral leadership in health care. There is growing recognition that responsible health care leaders must be sensitive and responsive to the people who provide the care as well as to those who receive it. Health care workers, including nurses, are prepared no longer to have little or no input to the nature and shape of the health care system. They realize that they have knowledge and experience that suggest directions for health care and they insist on being heard. If their advice is sound, it will contribute to the optimization of the use of human and physical resources. It has been suggested that if the health care industry is to fulfill its mandate, the wise manager would be prudent to examine, with his peers and other colleagues, the goals of his institution in the light of present social needs and current fiscal realities and to ensure that the services of the institution have relevance for the needs and aspirations of the citizens of the community. The alternative is organizational obsolescence [19]. Improvement of the health care system can be done only by the providers of health services who must work within the resources allocated to them. They also must work cooperatively with the other disciplines and services involved to provide a health care system in general and specific services in particular that are most appropriate for the people to be served in the particular context.

In conclusion, although the essence of human actions lies in the heart and soul found in them, actions are judged by the difference they make in the world. Effective nursing practice depends as much on the humanity of the nurse as it does on the nurse's knowledge and technical skill.

Nurses who recognize and respond to the human needs of patients discover a rich source of knowledge and understanding. Nurses who respect and collaborate with colleagues find strength and support. The professional roles of nurses and the human relationship inherent in them include specific responsibilities, privileges, and rights.

The nursing profession, as part of its constant pursuit of optimal impact, is keeping nursing's ethical dimension under constant scrutiny. This is part of the challenge that we, the nurses of the 1980s, have accepted: to subject our own profession to constructive criticism in order to determine the need to transform the old order into a new and better one. Such action will not provide solutions for all of the ethical problems in nursing practice. However, it can stimulate us to continue to strive for excellence, to apply appropriate ethical concepts to the situations in which we work, and to be sensitive to the need for thoughtful and sound decision making in the face of ethical dilemmas.

I believe that ethics and nursing practice in the 1980s *can be* compatible. However, they *will be* compatible only if we, as nurses, *make them* compatible.

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Treatment

Legal Implications of Standards of Nursing Care

K. Scherer

1 Introduction

With the evolution of nursing from the physician's handmaiden role through the apprenticeship period to full professional status, many changes have occurred. Fundamental to these changes has been the transformation of the definition of nursing practice. Once it was subsumed under the definition of medicine; however, many jurisdictions now have a unique definition of nursing practice contained within legislation. While earlier definitions tended to be task oriented, current definitions of nursing practice tend to be broad and general. Although supportive of a more independent practice base, they have necessitated the formalization of standards of practice in order to describe nursing's accountability and responsibility. The need to describe what constitutes competent nursing practice is most clearly perceived when a nurse is accused of negligence or incompetency.

Certainly in common law countries, the expert nurse witness has a long-standing tradition of providing testimony in cases of negligence and incompetency. Generally, an expert nurse witness provides a reliable opinion about the standard of care that can be expected to be provided by a "reasonable and prudent" nurse in cases of negligence. In cases of incompetency the nurse witness provides an expert opinion supported by professional credentials about the standard of care provided by competent practitioners in the same locality. The testimony provided by these experts traditionally has been viewed as the criterion by which nursing behavior may be evaluated. However, this tradition of the expert nurse witness has been far from satisfactory, for it embodies an oral standard of nursing care. As nursing moves from a dependent, task-oriented base to a more independent, decision-making base, the replacement of this oral standard, as exemplified in the expert nurse witness, by formalized standards, is required.

As the professional nursing association in the province of Manitoba, Canada, the Manitoba Association of Registered Nurses (M. A. R. N.) has a mandate to protect the public interest by insuring that qualified nurses are licensed and practice nursing in accordance with professional standards. The revised Registered Nurses Act of 1980 empowered the M. A. R. N. Board to "develop, establish and maintain standards for the practice of nursing" [8]. The purpose ot this paper is to describe the establishment of content validity in the second edition of the M. A. R. N. Standards of Nursing Care [7] and to explore the legal implications of these standards by examining alternatives to the expert nurse witness.

2 Materials and Methods

From October 1979 until May 1981, collaborative research was conducted by the M. A. R. N., and the University of Manitoba School of Nursing for the purpose of revising the M. A. R. N. Standards and establishing the content validity of these standards. While the methodologies have been described in earlier papers [4, 5], I will briefly summarize these now. The approach to content validation of the M. A. R. N. Standards is a unique achievement in North America and set the basis for the current development of valid and reliable instruments to measure the standards.

Measurement theory from the disciplines of education and psychology has specified content validation procedures. Our application and further refinement of these procedures resulted in the following methods: First, a review of the nursing and quality-of-care literature was conducted. From this review the behavior domain to be measured in the Standards was identified and the conceptual framework for the behavior domain and its evaluation was delineated. Next, subject matter experts were consulted to identify the content sampling of the behavior domain. Finally, the resulting criteria and standards [1] would serve as the test specifications for future measurement items by identifying the kinds of topics to be covered.

From the review of the literature, the practice of nursing was conceptualized as the universe with four behavior domains: research, education, administration, and clinical nursing or direct nursing care. Direct nursing care was selected as the behavior domain for the establishment of standards. From the literature review we were also able to formulate our conceptual framework which included the nursing process; Donabedian's [2] model of structure, process, and outcome; and Williamson's [9] outcome framework of diagnostic, therapeutic, and educational outcomes.

The second method in establishing content validity would be the formulation of criteria and standards thought to be indicative of the quality of direct nursing care, within our conceptual framework. The explicit method of developing an objective list of criteria, against which raters would evaluate care, was selected. Two methodologies for developing explicit criteria have been reported. The first entails using experts to establish normative standards, while the second entails using practitioners to develop empirical standards. A decision was made to use a blend of the normative and empirical methods of setting explicit criteria, that is, we would use experts and practitioners. This blend would provide us with a more solid base for the establishment of content validity.

Consultation with subject matter experts was the next step in the content validation procedure. The M. A. R. N. Special Committee on Standards was the first expert group and was composed of 16 members representative of all areas of nursing in the province. Over a 7-month period, criteria and standards thought to be indicative of the quality of direct nursing care were developed.

Other subject matter experts and practitioners were selected from the sampling frame of the population of active practicing nurses in Manitoba. The population was stratified based on the type of employment and four major strata were selected and operationally defined:

1. practitioners involved in direct nursing care,
2. administrators,
3. researchers, and
4. educators.

The sample size of each stratum was determined by proportional random sampling without replacement. The barriers encountered in identifying and accessing the populations of educators and researchers and our subsequent decision to identify these populations in Canada, as well as to sample from the membership list of the American Nurses Association Council of Nurse Researchers, is reported elsewhere [4].

A questionnaire was developed in order to elicit opinions about the Standards from this sample of nurses. In designing the Delphi questionnaire we were mindful that one of our content validation tasks was to ascertain not only that the Standards were "desirable" but also that they were "necessary." In order to accomplish this, three questions were asked.

Question 1. In general, across all types of nursing settings, this item must be present and/or put into practice in order for good nursing care to be provided. Do you strongly disagree, moderately disagree, neither agree nor disagree, moderately agree, or strongly agree?

Question 2a. This item may or may not apply in your setting(s), for various reasons. However, the present standards indicate that each item *should* apply. Do you strongly disagree, moderately disagree, neither agree nor disagree, moderately agree, or strongly agree that this item *should* apply in your setting?

Question 2b. At the present time *does* this item apply in your setting?
Respondents were asked to reply to the three questions in relation to each of the criteria and standards. The questionnaire was pretested by the Standards committee and 16 nurses representative of the study population.

3 Results

The overall response rate to the questionnaire was 73% and resulted in achievement of consensus. For the first question, the resulting mean scores on a scale from 1, "strongly disagree", to 5, "strongly agree", ranged from 3.6 to 4.9. The overall mean response to the first question was 4.59 and to the second question was 4.5. Having developed the Standards, we now needed to consider what legal implications they may have.

4 Discussion

In Manitoba, as in all provinces except Quebec, the legal system is based on English common law and statute law. Let us first consider the legal implications of the Standards under statute law. The statute governing the practice of registered nurses in Manitoba is The Registered Nurses Act [8]. The M.A.R.N. Standards of Nursing Care could be submitted as a Regulation to The Registered Nurses Act, subject to approval of the Lieutenant Governor in Council. However, this is a prolonged procedure and does not permit flexibility in revising the Standards to reflect changes in practice, and this is not being considered by the M.A.R.N. Board.

The Manitoba Legislative Assembly has delegated the authority for administering The Registered Nurses Act to the M.A.R.N. Within the Act, the M.A.R.N. fulfills one of the requirements of a profession, that of self-regulation. To accomplish this the Act provides a two-pronged mechanism in which nurses accused of professional incompetence to practice are referred to a Complaints Committee in an attempt to informally resolve the complaint. Professional incompetence refers to a lack of knowledge, skill, or judgment in caring for a patient or disregard for the welfare of a patient [6]. When a complainant does not accept this informal resolution or it appears that there are grounds for further action, the matter is referred to an investigation chairman who conducts a preliminary investigation to determine whether an inquire should be held by a Discipline Committee. Decisions by the Discipline Committee may be appealed to the M.A.R.N. Board or the Manitoba Court of Queen's Bench.

Although in the last 10 years we have had only one formal complaint concerning a member's professional incompetence, we do not expect this pattern to continue. What I would like to explore and discuss is the current dilemma which confronts the M.A.R.N., vis-à-vis the legal implications of the Standards. Prospectively, M.A.R.N. members accused of professional incompetence could be encouraged to enter the Standards, or pertinent parts of them, as evidence to defend their conduct. On the other hand, specific criteria from the Standards could be entered as evidence by the M.A.R.N. in order to evaluate the member's competence. It is anticipated that the clarity of the Standards, the consensus achieved in the content validation procedure, and the widespread utilization of the Standards in practice would enable members to defend their practice as meeting the Standards. From a legal point of view, this process poses no problems.

However, from a strategic and political point of view, the use of the Standards for disciplinary purposes could be very problematic. During the development of the Standards, membership was informed that the intent of the Standards was to improve the quality of nursing care. Implementation and evaluation of the Standards in an agency could provide baseline data from which educational programs could be designed and their effectiveness in improving the quality of nursing care could be monitored. Because of the intent of the Standards and the membership involvement in their content validation, there has been widespread acceptance and utilization of the Standards throughout Manitoba and in agencies in other provinces.

The utilization of the Standards for disciplinary purposes, rather than for educational purposes, could entirely change that membership acceptance. In other locations, this is already occurring. You may be aware that recently in the United States in the state of Iowa [3] the nursing association, the hospital association, and the medical society successfully opposed the minimum standards developed by the Iowa Board of Nursing. The Standards were opposed on the basis that they were too specific, as to invite malpractice suits. While the Iowa Standards were developed without the type of membership input that went into the M. A. R. N. Standards and also for the sole purpose of disciplining members, what is of concern is the tremendous membership opposition.

Let us now examine the legal implication of the Standards, which relates to common law. English common law is based on precedents. Through the accumulation of judgments arising from individual cases, a body of law called case law is developed. It is anticipated that individual parts of the M. A. R. N. Standards may become accepted in case law over a considerable number of years. M. A. R. N. members accused of negligence or incompetency in civil proceedings could be encouraged to utilize an expert nurse witness and cite pertinent criteria from the M. A. R. N. Standards. Thus testimony would be given by the expert nurse that the M. A. R. N. Standards are actually recognized by a reasonable, competent nurse as appropriate clinical standards. Should the Court upon examination of the evidence accept a particular Standard, that portion of the Standards will have been accepted by the Court and embodied in case law. Once a particular section of the Standards has been accepted by the Court, because of the role set by established precedents, it will be easier to have the same part of the Standard accepted on subsequent occasions without the use of the expert nurse witness. It could also influence the Court to accept other parts of the Standards in other circumstances.

In conclusion, I have described the establishment of content validity in a second edition of the M. A. R. N. Standards and have explored some of the potential legal implications of Standards.

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Practice and Malpractice

K. M. J. Rea

1 Practice: Duties and Rights and Authority

Each nurse owes her patient a duty of care. That duty is owed by each person to his neighbor. In English common law, a "neighbor" was described by Lord Atkin in the 1932 case of *Donoghue* v *Stevenson* [1] as:

> persons who are so closely and directly affected by the act, one ought reasonably to have them in contemplation as being so affected when one is directing one's mind to the acts or omissions which are called into question.

That duty of care is relevant to the nurse's practice because it is the foundation upon which any action in negligence is based. After the duty comes the breach of that duty, and from that, the resultant damage.

What is a nurse's duty of care? Everybody is different. Every nurse has differing and varying opinions of what level of care she owes to her patients, whether she be on the ward or elsewhere.

The law on the area of duty of care talks of the "reasonable practitioner" test of the correct way to do a procedure, the reasonable doctor, hospital, pharmacist, radiographer, architect, barrister. There is a plethora of case law on this area.

Let us first look briefly at the doctor's duty of care. It varies according to:

1. The individual doctor's responsibility in that situation, namely his job description (houseman, registrar, consultant)
2. The circumstances existing at the time of the accident, for example staff shortages, the patient's condition, even the doctor's condition! even!
3. The background of what a reasonable doctor would do in those circumstances, namely, the objective test supplemented by a subjective test

Now, to see what a nurse's duty of care entails, one would have to apply by analogy those experiences already gained in litigation against nurses in England (none) and those court cases including doctors (quite a number), and to see what the judges considered the standard measure of the duty of care.

There is no time to do that now, so I will pass on to the nurse's differing situations.

1.1 The Ward Nurse

One might say that the ward nurse is in the enviable position of having everything she needs to care for her patients at her fingertips. At this juncture, I hasten to add that I realize that not all wards, either in Great Britain or over the rest of the world, are adequately equipped for lots of reasons, but mainly financial. However, I would distinguish the ward situation from the community situation, for example. The ward nurse will, nevertheless, have her problems. A busy, qualified nurse will be preoccupied with a number of things:

1. Her patients: their hygiene and treatment, intravenous regimes, medication, diet
2. Her documentation: reports, orders
3. The doctors: the ward rounds and noting the results
4. The physiotherapists: to whom they are allocated
5. The other paramedical staff, including the occupational therapists; the chaplain
6. The student nurses: teaching, explaining, guiding, rebuking, watching, allocating, and so on
7. The relatives: explaining, consoling, exploring
8. The ward: hygiene, cleanliness

The Staff Nurse, then, is a lady or gentleman of many roles. Her duty of care extends into each of these areas. She must use her theoretical knowledge, learned in nursing school, and apply that to the practical situation. In this situation, she must have in mind the theoretical side of her procedure, for example, the drug's names, both proprietary and original; its side effects and contraindications when she administers it.

That would apply to the intravenous infusion, for examples, to check the infusion being put up, with a witness present; to ensure that there is no contraindication with the previous infusion, such as administering dextrose after blood without changing the infusion set, because the blood will clot in the infusion line. It would also apply to intravenous drug administration, for in IV therapy, there is always the increased risk of error, by virtue of the fact that this direct method of administration has *immediate* effect.

Other dangers in this sphere include the calculations of the drugs heparin and insulin.

Special regard must, I feel, be given to the different types of syringes available in the world for insulin administration. Some have 20 divisions per milliliter, others have 10 divisions per milliliter. U-80 insulin will have a strength of 4 units per division with the first syringe, but 8 units per division with the second syringe. So it is a highly dangerous practice simply to *presume* in this area. I would, therefore, recommend that a nurse get paper and pencil and quickly calculate out how many units per space and divide her answer into the prescribed dose. This will give her the number of spaces or divisions to draw up on the syringe. I know it is laborious and time-consuming but it is safe - and safety is what this is all about. Mistakes can often be made, but more so under extreme pressure, in these days of staff shortages.

Each hospital nurse has her own area with which to contend, its specialities and difficulties. For example, the operating room nurse who has a duty to her patient, the surgeons, the anesthetists and others, including the operating department assistant and, of course, her own colleagues. This is much more a team effort than perhaps on the wards, for here her duty of care extends to others in that operating theater.

The accident and emergency nurse has to guard against the unexpected; the abusive or violent patient. She must be the type of person to act quickly and efficiently and, at the same time, take into account the results of her acts or omission.

The community nurse has quite different problems from the ward or hospital nurse. By the very nature of her job, fingertip luxuries are *not* before her. She is probably the type of nurse who enjoys the challenge of "making do". She owes a duty of care to her patients not to exceed her own limits. She is alone when she does her work and must guard against, for example, the temptation of trying to lift a heavy patient on her own. This could result in injury not only to her patient but also to herself. So we see here the nurse's duty of care extending to herself. It is clearer now, I hope, just on what fluctuating sands the duty of care rests. I will add four more general comments before moving on to malpractice.

1.1.1 The Student Nurse

The reasonable nurse includes also what would be reasonable for a student nurse to have done. So, for example, the standard hoped for from a first-, second-, or third-year student nurse, befits only, and no more, a reasonable first-, second-, or third-year student nurse. This is notwithstanding a case called Nettleship v Weston [2], where it was held that the standard of the duty of care of the learner driver was that of an ordinary, prudent, and reasonable driver, with a driving license and quite fully fledged. I believe that one cannot adequately equate a driver of a motor vehicle with a nurse. The student nurse does not know many procedures or a great deal of information when she is, let us say, a first-year student. The learner driver after just his first lesson, it is hoped, will have at least the car moving, which is after all the essence of driving.

1.1.2 The Senior Nurse

With regard to sisters, head nurses, nursing officers, directors of nursing services, district nursing officers, and regional nursing officers: their role is of great importance. Their duty of care differs from that of the lower eschelons, but it is still vital. The buck tends to stop elsewhere in these areas if something does go wrong (for example, if a negligence action is ensuing). Their liability is that of the overseer, the person who must certainly satisfy herself that the workforce beneath her is doing its allocated tasks in a reasonably safe and caring manner. The District Health Authority (DHA) takes the responsibility of the erring nurses for some negligent acts or omissions. Nevertheless, as stringently as the DHA would investigate the ward nurse's acts or omissions, so it would also investigate the senior nurse's position to see if she had adequately protected the patients from that nurse by overseeing those acts or omissions, whether she had acted correctly in reporting the misfeasance to her own seniors, and whether she herself could or should have intervened to stop the negligent act or omission occurring initially.

With increasing technology and documentation all trained nurses are now finding their workload and responsibility increased. And I would say this: it is a legal maxim but it applies so aptly to the health services around the world: "The greater the risk, the higher the duty of care."

1.1.3 Documentation

With regard to this, in England, at present, we now have the gradual implementation of a method of nursing called the nursing process. Some of you may already know this from your own countries, especially the United States. I believe it is still at embryo stage in England and there is much discussion still on its legality and use. The document side of it replaces the old visual display unit, sometimes known by the proprietary name of Kardex, which all nurses were told in the past was "the legal document". No one really gave much thought, until recently, to this, until suddenly we were confronted with a bundle of documents called the nursing process, and then thought, well how can all *that* be the legal document? This has yet to be decided upon, but one problem here is relevant: the duty of care as described under the "Plan" section. This often results in the nurse having to commit to ink and paper how long *she* estimates the pneumonia to resolve or the pressure area to disappear, to give but two examples of patients' problems. Additionally, the trend in England is to share this documentation with the patient, which itself has problems to do with "secrecy". What happens if the patient sees that his pneumonia after 10 days has not resolved as the nurse expected and wrote down, but instead that it had worsened. Is the nurse here in breach of her duty of care to the patient in not so "curing" him? Some would argue that it is so; others, that one could say here that the patient could be told that no matter what was put down in writing, nothing can guarantee the plan to work to the day, such is the inconsistent workings of the human body. It is an unpredictable area. Nevertheless, some litigious patient might take advantage of such a situation. He would have good ammunition for a claim in negligence. This is the lower end of the scale, but other hospital-induced complications can be deep vein thrombosis and pulmonary embolus, for example.

1.1.4 Litigation

I must point out now that the incidence in England, for suing nurses in their own name, is rare; indeed there are no such reported cases in the law books. Instead the Authority takes vicarious liability (a form of secondary liability) for the nurse's actions or omissions, if the nurse is contracted to work for the Authority.

However, it is changing; the British public are now (one *could* say, at last) becoming more educated in their legal rights when they enter hospital. The Carol Brown case, to name but one highly meritorious claim, puts three midwives in somewhat dubious limelight.[1] It must be emphasized now that no matter what the patient feels about his claim against the Authority, there is a danger - small hitherto - that if the nurse either acts outside the scope of her employment (for example, has a drink in a public house instead of doing the drug round) and is, in effect, to quote one of our Law Lords "on a frolic of her own," or has acted in so grossly a negligent manner as to take her outside the duty of care in which a "reasonable" nurse would

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[1] The Carol Brown Case was unreported, save for newspaper reports at the time, of the amount of demages awarded since the case, although litigated briefly in Court, did not reach the stage for Judgement from the learned Judge. It was settled before that stage

act, then the Authority could either refuse to take vicarious liability for her or ask her for an indemnity by way of third-party proceedings, when the patient sues the Authority.

Luckily to date the public may have either

1. failed to recognize the essence of primary as well as vicarious liability or
2. taken the attitude that, even if they did recognize it, the likelihood of suing an individual nurse is remote because of the British image of the nurse - the administering "angel" - and her impecuniosity, or both.

I say this guardedly, for I and my colleagues already begin to sense, day by day, when we nurse in the true practical sense, the rumbles of complaints, abruptness, and simple ungratefulness. It is a vicious circle and one which breeds more defense mechanisms; and Heaven help us if we end up as "defensive" practitioners. This area could be discussed at great length, bearing in mind comparisons with the United States and the increasing trend in England towards "privatisation". I will end this portion by simply advocating, again, with undiscussed reserve, the Swedish and New Zealand "no fault" system. Again there are certain criticisms of the Accident Compensation Corporation scheme of New Zealand which are beginning to be manifested, I believe.

2 Malpractice

Malpractice is really the breach of the duty of care I have outlined earlier, in simple terms, with the resultant damage to the patient/victim.

1. I have just a few examples for you: A newly qualified doctor prescribed 5 units of insulin to be injected intramuscularly into a patient with dangerously high potassium levels and a provisional diagnosis of malaria with hepatorenal failure. The nurse administered the insulin in a large syringe. She had given 5 ml of insulin instead of 5 units, 40 times the normal dose. The patient later died.

2. Ether was used in skin preparation in an aortoiliac reconstruction on a patient with intermittent claudication. Later, a femoral arteriotomy was performed during which the surgeon called for heparinized saline to inject into both common iliac arteries. He was handed a syringe with an attached cannula, by the nurse. The cannula stopped working and was drawn out. The plastic had dissolved and one artery was eroded. Efforts to revive circulation in the leg failed and at a later date the leg was amputated. The nurse had negligently used the same gallipot for the heparinized saline as she had earlier used for the ether, leaving residual ether in the gallipot, and allowing its introduction through the cannula into the artery. The relevant Health Authority eventually settled the claim on behalf of the nurse concerned.

3. The Carol Brown case. An epidural anesthetic was administered to Mrs. Carol Brown to aid in the labor stages of the delivery of her son. That was several years ago. Today she is paralyzed below the waist; has restricted arm movements; and persistent pain in the lower chest, arms, and feet, due to negligent administration and/or lack of administration of an additional dose of the epidural. In January

1982, Carol Brown was awarded £ 414,563 after Mr. Justice Taiyler found the Area Health Authority (AHA) vicariously liable for three midwives present at the relevant times. The AHA took liability in two ways:

- for the midwifery sister for inadequate supervision of the two staff midwives, and
- for the two staff midwives (one of whom was an agency nurse) who failed to "top up" the epidural at the proper time, or, alternatively who inadequately topped it up. Neither had the necessary Certificate of Competence to do such a procedure.

Now the Royal College of Midwives and the Central Midwifery Board are to issue a joint statement clarifying the role of midwives called to administer such an injection. A midwife may now only top up or administer the epidural if she has been properly trained or instructed, but the responsibility of ensuring she is competent rests with the local employing authority.

Rather like shutting the stable door after the horse has bolted, one might be tempted to say. Alternatively, better late than never. Malpractice is like a great dam ready to burst. One keeps "patching up" the parts that crack and leak, and it stays moderately intact, but that cannot last forever. One day the dam might burst and then we will be flooded with claims. That is why it is better to prevent rather than cure.

3 The Emergency Situation

There are various situations where emergency treatment will be required: in the emergency room, the operating room, the intensive care units, the coronary care unit, on the wards, in the community, in midwifery, and, of course, on the highways and byeways. Each nurse (as I have already discussed in this paper) has her own duty of care within her own speciality or sphere.

It will, nevertheless, be recognized that in an emergency situation the nurse is working under more pressure and stress than usual. In juxtaposition to this, one has to remember the higher the risk, the greater the duty of care.

In the resuscitation situation the nurse must take extra care with the drugs. She and the doctor will be using drugs as called out by the doctor, as passed to him to use by the nurse, which might not be noted, and might be forgotten later when the situation is calmer. Use of another nurse to note names, dosages, routes, and the doctor's name would be wise, if there is a nurse to spare on the ward. This information can then later be prescribed by the doctor and signed off by the nurse in the usual way, with the records made in the nursing notes, if that is the practice.

Care in the use of the defibrillator is important. The obvious dangers here are electric shock, burns, death from wrong or incompetent use of such a machine. The doctor is the only person, in England, who is permitted to use it on the patient, although the nurse is permitted, and often required, to check it. The electrocardiogram is also another area where care must be used, for if the nurse holds herself out to do such a procedure and it is done incorrectly, it could lead to unnecessary alarm and timewasting, for the doctor will have to do it again. For this reason, many nurses refuse to do an ECG for the doctor. This and other "requests" are examples where the duty of the nurse is inadvertently widened because she is either unwilling to acknowledge her own limits (there is "kudos" in doing an ECG for a doctor) or is too confident of her abilities. Needless to say, this would hopefully not apply to a fully trained coronary care nurse.

The casualty nurse must guard against improper information being conveyed to patients, either over the counter or on the telephone. Here she is far more vulnerable than her counterparts for she is on the direct "firing line" of the public (excuse the phraseology!). Diagnoses over the telephone must be avoided no matter how persistent the potential patient is. No doctor worth his salt would do so, and it is not, therefore, for the nurse to do such a radical thing, tempting though it may be.

I will conclude this section by saying that these examples are by no means an exhaustive list of situations in which to take added care. That would take a long time to postulate. I leave these to the individual's common sense to cope with, for one can be too "spoon fed".

4 Legal Proceedings: Nurses in Court

There are four main areas in the United Kingdom in which a nurse may be required to attend a court of law:

1. As a witness in the coroner's court
2. As an expert witness
3. As a witness of fact
4. As a defendant in a civil action

As a witness in the coroner's court the nurse gives her evidence relating to her words or actions at the relevant time. She will be guided through this by her own lawyer and often the coroner, an experienced doctor and lawyer. Then she will be cross-examined by the deceased's lawyer if her actions leave any room for doubt. Re-examination takes place to clarify any points in cross-examination. Everybody in the coroner's court is there to see the truth elucidated in the best interests of the deceased person. Sometimes it is easy to mistake the family's interests as being paramount, with regard to potential legal claims and possible damage, but in theory this should not be so.

As an expert witness, the more technological nurses become, the more judge's deem them to be experts. When giving expert evidence in court, she must be careful not to give her personal, nonprofessional opinion, nor an opinion based on hypothesis. As a factual witness, the help a nurse in this instance can give would include reading out an undisputed fact of the nursing record in order for the court to obtain a chronological sequence of events, on the day in question, for example. Also if she is the owner of an agency she might give evidence as to cost with regard to the future care, in monetary terms, of an accident victim who was, as a result, severely handicapped and needed a private nurse.

As a defendant in a civil action. This would be an unfortunate court appearance, but one which should not necessarily fill the nurse's heart with fear. Provided she remains clear, concise, and answers in a loud voice, looking at the judge, she should find that he will regard her with the professionalism which she deserves (whether that be a great deal or a small amount). No matter how negligent the nurse has been, if she tells the truth initially when her own lawyer is examining her, she will find cross-examination much less onerous, for a good lawyer will try to preempt any awkward areas before cross-examination. Sober dress is recommended. So have no fear. Everybody in court is there to help, not to hinder, and nurses are highly respected as a profession by judges.

5 Professional Secrecy

Finally I come to the last topic in my paper. How desirable is secrecy in our profession? Does it have a place? One has to balance the rights of the patient to know and see documentation written about him, against the possible breach of confidentiality of what could often be sensitive and embarrassing areas, and comments about the patients diagnosis and prognosis. This type of breach *could* occur *to* the patient directly or to somebody else who has obtained certain nursing and medical records. Often patients, by implication, do not wish to know their diagnosis if, for example, that diagnosis is cancer. The nurse must judge as she sees it fits the individual circumstances.

This secrecy can be encroached upon. It is in the areas of release of documents to the patient with litigation in mind that the English law has manifested the current trend of thinking here. As a result of a 1978 case [3], the government passed the Supreme Court Act 1981, codifying the law, until then. It took effect on 1 January 1982. Its effect was to make available to the patient/victim/applicant and/or his legal advisor and/or his medical advisor (or other professional advisor), *before* or during legal proceedings, if the court so orders, such relevant documentation as the court deems necessary and reasonable. The applicant has to be a potential litigant in subsequent proceedings. The change in the law here is that now, if ordered, the Authority and/or the doctors have to release such documents to the *patient,* who can read them himself. Hitherto, the documents were habitually released to the legal advisors and occasionally to the medical advisors, but very rarely could the patient read them.

What untold damage can it now do to the patient to see in cold print such things written about him as "this discontented elderly man ..." (in the doctors' notes) or "patient was extremely uncooperative and obstructive today. Recommended for sedation" (in the nursing notes)? We speak of "professional secrecy" and many correlate that with the word "whitewash". That is not so. The secrecy (and I prefer the word confidentiality) is not only to safeguard doctors and nurses against defensive practice, but also to safeguard the patients against themselves, and that cannot be emphasized too greatly. To some extent some secrecy must be preserved for these reasons and also to prevent the "fishing" expeditions in which the over-litigious patient could indulge if he finds himself without a cause of action, but wants to find one, from his notes.

The Medical Protection Society of Great Britain [5] has issued advice in a leaflet about confidentiality, which recommends the doctor and Health Authority to encourage voluntary disclosure of such information. This means that the applicant must swear an affidavit giving *reasons* why he wants the requested documents. If either he is unwilling to swear the affidavit, or the Authority feels that the reasons are inadequate, then the applicant is advised to obtain a court order for disclosure of the documents. Thus, initially at least, friendly helpful moves may be made by both sides, for nobody wants to deprive the genuine hospital accident victim of his compensation.

So it seems that we must take a leaf out of our colleagues' (the doctors) books and attempt to participate in voluntary disclosure at the Regional Health Authority level, with proper legal advice. Very recently, it has been held in quite clear terms that nurse's reports are, sooner or later, if relevant and reasonable and if the court so orders, bound to be disclosed to the patient [4].

Again, is the patient's right of confidentiality going to be eroded if the nurse openly uses the nursing process documentation in the ward with the patient? There are dangers of overexposure of this document: a nosy neighbor or a curious visitor or relative may read it if it is left at the end of the bed, as they indeed are in some English hospitals. The balance has yet to be resolved either in the wards or in the district, but with foreknowledge of the dangers, one hopes they will be avoided in practice.

I leave you with some thoughts. When we raise an arm to start treatment on a patient our duty of care begins.

Ask yourself:

1. What is my duty of care to the patient?
2. How much risk is there to the patient?
3. And then add the cream to the milk - the higher the risk, the greater the duty of care. The greater the duty of care, the greater the care to be actually taken in practice; but at the same time let us *not* become "defensive" nurses.

Florence Nightingale, in whose training school I had the honor to be trained, started it all; do not finish it by dripping the burning oil from your lamps on to your patients.

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Legal Aspects of Surgery in England

E. Dixon

From Queen to commoner, we must all render obedience to the law. "Justice, Sir," said Daniel Webster, "is the great interest of man on earth." Law is something that changes and can be altered if justice demands it. English law is partly written and partly unwritten. Written law is statute law and it consists of acts of parliament. A good deal of English law rests on custom, or what has been done before, and is called common law.

Nurses must not only live according to the law of the land but they must also practice within the legal confines of their professional qualifications. They are responsible for their professional practice to the General Nursing Council, which will eventually be replaced by the newly established statutory bodies of the Nurses, Midwives, and Health Visitors Act.

The law protects the rights of patients, and in the generality of cases, surgery cannot be performed without the patient's consent. Failure to obtain this consent will usually amount to actionable trespass to the person for which the surgeon and those helping him may be held personally responsible.

Consent can be oral, written, or implied and all are of equal value in law, although written consent has the advantage of providing a permanent record. To be valid, consent must be given freely and given only after the proposed operation has been explained to the patient by the surgeon.

The law courts are the headquarters for the administration of justice in England. Patients are due what is termed "a duty of care" and if they have reason to believe that there has been negligence in the delivery of this care, they may well resort to litigation. Although alarmist publicity of alleged unethical or criminal activity by a few doctors or nurses is welcomed by some sections of the press, professional integrity and high ethical standards are still the rule rather than the exception.

For elective surgery on children from birth to 16 years, the parents' or guardians' consent is required. Young people between 16 and 18 years can give consent for medically necessary surgery.

The consent of a spouse is not a legal requirement for a medically necessary operation (for example, a hysterectomy) but as a matter of good practice, it is considered a wise precaution to obtain it.

In the case of the mentally handicapped patient, the medical officer will decide if the patient is capable of making a decision; otherwise, permission is sought from a relative or the medical officer will decide.

In all cases requiring emergency treatment, the surgeon will operate as soon as possible, whether or not consent is given or available. There is no rule of law which prevents a patient electing to go to his own death, but it is not to be expected that a court would readily find against a surgeon who, in a case where prompt action was required, had taken a course approved by a substantial body of medical opinion. In the case of a child, it is the surgeon's duty to do all he can to save the child's life, and if he fails in that duty, he might be charged with manslaughter. By providing necessary treatment, he is doing no more than is the duty of the parents, and he may, if necessary, apply to have the child made a ward of court.

The objection of an adult to elective surgery on religious or other grounds will always be respected. The same principle applies in the case of children but the surgeon has a duty to explain to patients the possible consequences of this action.

Two important booklets are published jointly by The Medical Defence Union and The Royal College of Nursing, recommending a code of practice to be followed to prevent mishaps occurring during surgery. These documents outline procedures which should ensure that the wrong operation is not performed and also that swabs, needles, or instruments are not left in the wound.

The operating room nurse carries-out a preliminary count, which is repeated before the incision is closed, and again at the end of the operation.

The count is recorded and retained in the patient's notes.

The booklets are recommendations - not laws - but failure to comply with them constitutes negligence, which will be acceptable as evidence in a court of law.

Current legislation makes it mandatory for hospital authorities to ensure that the operating room provides conditions of optimum safety for both patients and staff. Some of the precautions taken are as follows.

All floors have antistatic properties and movable equipment is fitted with antistatic wheels.

Ventilation and humidity has to conform with Department of Health standards.

All electrosurgical equipment is insulated.

A strict Code of Practice ensures that staff are protected from radioactive substances.

For every surgical procedure, a strict count is carried out.

Regular checks by health and safety officers ensure that potential hazards are identified and corrected.

Regular educational programs ensure that staff are conversant with developments in technology and equipment.

The Hospital Authority and the unions will provide legal advice and guidance for staff involved in legal proceedings.

The Abortion Act 1967 allow nurses to refuse to participate in procedures which terminate life. Nurse's objections may be based on religious, moral or ethical beliefs, but the Act also states "there remains a duty to participate in treatment which is necessary to save the life or to prevent grave permanent injury to the physical or mental health of a pregnant woman."

The Health and Safety at Work Act 1974 states "It shall be the duty of every employer to ensure so far as is reasonably practicable, the health, safety and welfare of all his employees." Failure to comply with this constitutes negligence. A large number of scalpel blades and needles are used in the operating room daily. They constitute a continual hazard to staff but when a safe method of disposal is used there is a decrease in occupational illness and a reduction in the amount of money paid in compensation to staff due to accidents.

British justice stands high in the esteem of the world, and the law protects contracts and agreements made between patients and the professionals who care for them.

Legal and Moral Rights of Mentally Ill People: A Critical Argument

R. A. Schröck

One debate which engages a number of nurses, and to a larger extent other health care workers, voluntary organizations, and patients, is concerned with the "rights of patients," and predominantly with the rights of mentally ill and mentally handicapped people.

Much of the debate, however, is conducted on hand of concrete examples which are meant to illustrate the breaches of such rights in particular and individual instances. Without suggesting that such examples of instances of deprivation or ill treatment are invalid or inappropriate, it is nonetheless rare that any attempt is made to examine and to define the nature of such rights in a caring, professional relationship.

1 Nature of Human Rights

The conception of human rights in a context which must imply a particular view of man and society is embedded in the rise of individualism and in the development of social contract theories in the seventeenth and eighteenth centuries, which held as their most fundamental and common tenet the principle "that the basis and end of government (is) the security, the happiness, the rights of the individual" [1].

The ensuing declarations which expressed some human rights as ideals or demands served obvious political purposes. But while these various conceptions of human rights were purposefully applied to political issues, they had originated in religious conceptions, conflicts, and martyrdoms of earlier times. The eighteenth century with its doctrines of the rights of man invited a new argument, which for the first time based its reasoning on philosophical analysis rather than on religious convictions. Closely linked to the notion of natural rights, which belongs to the realm of moral discourse, the whole idea of human rights is essentially a moral proposal.

> The doctrine of human rights is a proposal concerning the morally appropriate way of treating men and organizing society. Like all such proposals that gain force and command respect, it is a complex proposal, attempting to present a systematic view of man and society, taking up associated empirical material, relating and ordering moral preferences [1].

I will therefore argue that a discussion of patients' rights should be part of professional ethics in its proper sense, that is, prescriptions relating to patients' rights should be examined in such a way that the nature of the moral judgment required by the nurse in deciding on the "right" nursing action becomes clear and explicit. With the emergence of patients' rights into the consciousness of nurses and other health care workers and of patients themselves, it has become obvious that the moral proposals which are articulated in the declarations of such rights, which can readily be found in the North American nursing literature, are not necessarily realized in action. It may be pertinent to note that no such declaration has been fully reproduced and discussed in the British nursing literature.

The original idea of human rights, which defined certain areas of human conduct and affairs to be immune from government interference, also embodied the notion that the people could use justified force against the government if their rights were not protected by governmental action [2].

One important feature of both legal and moral rights, it seems, is their connection with coercive power.

John Stuart Mill [3] declared it an injustice to take or withhold from any person "that to which he has a *moral* right." He believed that

> "When we call anything a person's right, we mean that he has a valid claim on society to protect him in the possession of it, either by the force of law, or by that of education and opinion."

But not all human rights enjoy the protection of legal enforcement or the force of public opinion. Nevertheless, there appears to be a conviction among British psychiatric nurses and other workers in the mental health field that the protection of the rights of mental patients lies primarily in the hands of the law.

2 Legalistic Conception of Human Rights

A scrutiny of British standard nursing textbooks will confirm the impression that nurses hold a very legalistic concept of the nature of patients' rights. The only reference to patients' rights occurs in sections devoted to legal aspects of psychiatric care. The legal aspects, at any rate, are emphasized in theory, if not always in practice. The Mental Health Acts, which are the relevant acts of parliament, instruct nurses in the legal provisions concerning the detention of patients in institutions against their will, treatment without the patient's consent, care of property, guardianship, and the limited protection of the law against assault and invasions of privacy.

Furthermore, most of this instruction is secondhand, that is, few nurses study and discuss the actual legislative documents but refer to summaries and abstracts based on someone else's selection from the relevant acts. There seem to be few opportunities for nurses to consider the principles on which that legislation is based. Lacking an understanding of the essential nature of the societal processes embodied in law, they also lack a basis for defining their own responsibilities in relation to such laws.

In the comparative absence of goal-orientated nursing based on a methodical assessment of individual patient needs, nurses lack a concrete formulation to help them translate legislative prescriptions into effective practice. This apparent ineffectiveness in dealing with the nursing problems presented in reality, as when a patient insists on leaving hospital who is not clearly certified and so not liable to automatic detention, causes nurses to demand more and better laws.

My thesis is that patients' rights are only partially protected by legal enactments and will ever be so, even if nurses become more proficient in implementing such laws in practice.

3 Relationship Between Legal and Moral Rights

The rights of mentally ill people must be seen in the context of the rights other adult members of their society enjoy, which are developed from and based on a *moral consensus*. Mutually agreed and customary expectations of what is right and what is wrong in human conduct inform and regulate all our relationships between one person and another; between groups of people, such as parents and children or teachers and students; and between individuals and formal social institutions, such as the church or the government. Not all the rights which an adult exercises and which she expects will be respected by others are guaranteed to her by law, or if they are, some can only be enforced if the breach of the law is obvious, substantial, and often extreme. Some examples will illustrate this point clearly.

As a friend I have the right to expect that my friend is loyal to me, does not tell tales behind my back, keeps his promises, and goes out of his way to help me. If he fails to do any or all of these things, I can hardly invoke the law, but I can protect my rights as a friend by a moral sanction, that is, by showing disapproval, or by even ending the relationship.

As a customer I have the right to expect that I am not cheated and that the goods I buy are in a usable condition. If I am shortchanged, I may apply a moral sanction by withdrawing my custom and by causing my friends to do likewise, or I may embarrass the shopkeeper by loudly complaining in the shop in the presence of other customers. If I consider that I have suffered serious harm or considerable inconvenience, I may take my complaint to an arbitration body or a tribunal, or perhaps even to court; that is, I may cause legal sanctions to be applied to the dishonest shopkeeper.

In some instances, I would have no choice but to rely on legal protection of my rights, if, for example, I were arrested wrongfully.

The common and criminal law of the country protects certain moral rights of the people. Legal rights are selected moral rights. Offenses against our rights which cause serious harm or injury to the individual, which are common, or which seriously threaten social cohesion are legally sanctioned. But the law cannot protect all our rights. To be legally enforceable, the potential breach of the law must be obvious, recognizable, even quantifiable, it generally must be public so that the complaint can be substantiated, and often it must be extreme.

4 Moral Offenses Against Mentally Ill People

From the evidence of many inquiries into medical and nursing practices in mental hospitals over recent years, there appear to have been fewer breaches of the law (though it may have been administered inefficiently) than moral offenses against the rights of mentally ill people, their relatives and friends, and staff who attempted to restore these rights.

These offenses included the right to adequate and stimulating occupation, the right to generally accepted standards in the variety of food and in serving it in a manner consistent with adult expectations, the right to drink when thirsty and not be denied essential fluid intake, the right to be dressed in a manner consistent with dignity and respect for people's customary expectations, and the right to be protected from exploitation by people who hold power over the smallest details of life.

As recently as 1976, an inquiry found widespread offenses of this nature in a particular hospital [4]. It highlighted the not uncommon practices of refusing patients their day clothes for long periods of time (in one instance a patient was kept in pyjamas and dressing gown for over 4 years), and of serious overmedication (often as a punitive measure after the patient had proved difficult or disturbing to the staff).

It found that electroconvulsive therapy was forced on patients who clearly objected to this form of treatment, and there was deliberate humiliation of patients by leaving them in soiled and wet clothes or beds.

Teasing to the point of irritation and anger appeared to be common, and frequent slaps on the face, cuffing and other indignities were not unusual. The report of this inquiry points out in many places that the right of the patients to respect and dignity was neither recognized nor consequently protected.

The fact that most of these moral infringements have been observed in long-stay wards of psychiatric hospitals and in mental deficiency care settings may reinforce the point made earlier that an important feature of both legal and moral rights is their connection with coercive power. These patients are the least powerful and have little contact with those who could exert power on their behalf. These patients are hardly able to employ moral sanctions against any transgressor, partly for lack of social skill, and partly for the real possibility of retaliation by the more powerful. Reports of inquiry by and large avoid blaming individuals and focus on criticisms of a system which fails to protect its most helpless members. Although there is little doubt that members of staff become as much victims of an inefficient and morally ambiguous system, there is a great danger in negating any individual or personal blame. Degrading and indifferent actions are carried out by individuals and not by abstract constructs called systems.

5 Moral Protection of Patients' Rights

It may have become clear that many of the moral offenses against mentally ill people are of a nature which does not make them amenable to legal sanctions. They are rarely obvious but often develop insidiously. From calling patients by stereotyped and stigmatizing names like "schizo," "psycho," or "junkie," there is a gradual but invidious development that leads to a whole range of derogatory and diminishing responses and to the kind of moral offenses that I have discussed. In often stressful situations, the incident may not even be recognized and far less can such occurrences be easily quantified. Most transgressions are certainly not public and are difficult to substantiate, even if they were of a nature that could make them sanctionable by law.

A moral consensus that accepts that patients generally are told far less than the truth, that they may be deceived "for their own good," that promises may be made to restore control which the nurse has no means of keeping, that a patient's physical and emotional privacy is invaded without any compunction in the furtherance of "therapeutic" approaches, and that loyalty to colleagues outweighs almost all other moral obligations provides the climate in which moral offenses against patients become inevitable.

The conclusion that the rights of mentally ill people are primarily upheld by the conscience of individuals and by the moral consensus of those who understand the nature of patients' rights and are determined to use their power to enforce them is inescapable.

The declarations of the patients' rights and their formal adoption by a professional group are seen by many as a first important step. It may be a sad admission that many nurses and other health care workers may not be able to articulate unaided the moral principles which should govern their relationships with patients. Jenny [5], an American writer, declares firmly that they need to be brought to the provider's attention, and although Annas [6] expresses the hope that following a period of education, "doctors and nurses will begin to afford patients their rights as a matter of course," he still feels that the patient at present needs an "advocate" who can represent his interests, who is only accountable to the patient, and who also has the power to enforce the realization of his rights.

Many writers identified various advocacy models such as patient representative, counselor, lay therapist, information provider, health care humanist (sic), watchdog, educator, spokesman, catalyst, and ombudsman. But these proposals remained quite vague and nebulous.

There are many perfectly obvious reasons why this role cannot be "split off" from other caring roles, the most important being that in fact any caring role becomes impossible when the patient needs to be "protected" against those to whom he must surrender himself in all his vulnerability.

It is only in each nurse's conscience, in the willingness to accept personal responsibility, in acting courageously on behalf of the patient, in being committed to the patient's interest that the moral and legal rights of each patient can be upheld.

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Involuntary Sterilization of the Mentally Retarded: Curtailing Procreation Rights of Persons with Diminished Capability to Claim Rights

S. T. Fry

1 Introduction

Early in 1979, a United States couple in the state of Maryland sought a court order to sterilize by hysterectomy their brain-damaged, 11-year-old girl. Within the context of the present laws in the state of Maryland, the court ruled that it had no power to order this procedure unless the procedure was for therapeutic reasons. The court even went on to state that if the legislature had wanted the court to have the authority to order nontherapeutic sterilizations, it "would have enacted an appropriate statute as have twenty-seven (27) other states in this country" [1]. Following this ruling, a group of Maryland parents joined together to lobby for a state law that would allow them to have their retarded children sterilized [2]. Their efforts resulted in several bills placed before Maryland legislators in 1981 and 1982 [3, 4]. Yet, to date, none of these bills has been made into law.

The concern in writing the Maryland bills to allow involuntary sterilization of mentally retarded persons is to ensure that the rights of the individual are adequately protected through procedural safeguards. This concern is appropriate considering the sterilization abuses of many retarded persons throughout United States history. From the notorious 1927 United States Supreme Court decision upholding a state of Virginia statute to allow the sterilization of 18-year-old Carrie Buck [5] to a recent decision allowing sterilization of a 19-year-old woman with Down's syndrome [6, 7], the United States courts have played a major role in involuntary sterilization decisions. While many of these decisions have, indeed, sought to protect the rights of the retarded, other decisions have allowed sterilization for morally questionable reasons [8, 9]. The major problem facing many state legislators, therefore, is the language of a statute allowing involuntary sterilization which cannot be interpreted by the courts in such a way that sterilization abuse can occur. At issue is the moral justification for involuntary sterilization procedures involving the mentally retarded and the legal language by which both substantive and procedural due processes are satisfied. During the past year, I have explored the various components of this process and justifications offered by the courts in recent decisions regarding sterilization of the mentally retarded. I have found that most justifications offered to date have not been sufficient, on ethical grounds, to authorize coercive intervention with liberty in the form of sterilization of mentally retarded persons.

In the literature supporting coercive interventions, in general, two justifying principles are frequently cited: the harm principle and the paternalistic principle. The harm principle justifies coercive interference with a person's liberty when there exists supportable grounds for believing that an individual or group of individuals has been or will be physically or mentally harmed [10]. The[1] paternalistic principle justifies coercive intervention with a person's liberty in order to benefit or to prevent harm to that person [12]. Court decisions in the United States have displayed a curious mixture and inconsistent application of these two principles as justifying reasons for limiting procreative rights. Thus, the first part of this paper explores the background of court decisions abridging the right of mentally retarded persons to procreate; the second part examines the use of the paternalistic and harm principles as justifying principles for involuntary sterilization of the mentally retarded.

It is the thesis of this presentation that in the case of profoundly, severely, and some moderately retarded persons, involuntary sterilization is justified by the harm principle, which can be demonstrated to be morally sufficient for coercive interventions. In the case of mildly retarded persons, however, involuntary sterilization requires an application of the paternalistic principle, which can be demonstrated to be *never* morally justified on independent grounds as well as in the particular case of involuntary sterilization of the mildly retarded. Thus involuntary sterilization of mentally retarded persons is only morally justified in the case of profoundly, severely, and some moderately retarded individuals.

2 State Authority to Allow Involuntary Sterilization

In the United States, the fundamental right to procreate lies within the liberty interests protected by the Fourteenth Amendment of the Constitution [13]. The right to procreate is regarded as fundamental because it is necessary to the very existence and survival of the human race. As has been pointed out by the courts, curtailment of this right by the state forever deprives a person of a basic liberty [14]. Thus, there must be powerful interests on the part of the state in seeking to curtail this right in any person, including the mentally retarded.

In the past, the state has intervened in this right either on the basis of its police power authorities or under its authority as *parens patriae* [15, 16].

2.1 Police Power Authority

In acting on the basis of its police power authority, the state acts to promote the health, welfare, and safety of the public and not for the benefit of any individual. Yet the state's power to curtail a fundamental right is limited by the due process and equal protection clauses of the Fourteenth Amendment. The state must show that its interest is compelling, that no less drastic means can accomplish the goal sought by the state, and no group of persons will be discriminated against by the statute under consideration. At the present time, interference by the state under its police power authority is limited where sterilization of the mentally retarded is concerned. The state has, however, acted on this authority in years past with devastating results [17, 15, 9].

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[1] The harm principle is usually considered to justify coercive interference with a person's liberty in order to protect a person from acting in such a way that he harms others [11]. Beauchamp [10] has, however, embellished Mill's principle of harm to include the notion of unknown harms to the self

2.2 Parens Patriae Authority

When intervening in liberty on the basis of its *parens patriae* authority, the state acts to promote the best interests of the individual affected. It does this by acting as a guardian would to individuals unable to care for themselves and is motivated, at least in part, by the benevolent purpose of securing the welfare of the incompetent [18]. The state acts so as to protect the incompetent from coercive interventions, since they are, by reason of incompetency, unable to question or challenge the intervention. Yet the state must at the same time "choose" for the incompetent (as he would choose) because the status of incompetency prevents conscious exercise of choice. Because of this difficulty it is claimed by some that *parens patriae* is not an adequate method for authorizing the sterilization of incompetent individuals. *Parens patriae* powers are so broad that they may lead to inconsistent decisions [18, p 330]. In addition, the doctrine may not provide the procedural safeguards necessary to insure an individual's constitutional protection. There is an additional problem created by the doctrine of *parens patriae* in that courts may not correctly "choose" for the incompetent and courts may inadvertantly open the door for potential abuse by its authority.

My own analysis of court decisions reveals that courts have interpreted decisions made under the various authorities - police power and *parens patriae* - differently. There appears to be an inconsistent application of these authorities from case to case and from state to state. In fact, the latest trend in the courts seems to be that courts themselves make involuntary sterilization decisions on the basis of the incompetent's best interests, instead of allowing parents or a court-appointed guardian to make these decisions. This is very evident in the court proceedings concerning Lee Ann Grady, a 19-year-old woman with Down's syndrome [6]. The court made its decision

> ... to further the same interests she might pursue had she the ability to decide herself. We believe that having the choice made in her behalf produces a more just and compassionate result than leaving Lee Ann with no way to exercising a constitutional right. Our Court should accept the responsibility of providing her with a choice to compensate for her inability to exercise personally an important constitutional right [6].

This latest decision is one of three approaches that are now possible in involuntary sterilization authorizations. As pointed out by Annas, the first or majority approach "is for courts in states that have no specific statutes authorizing sterilization simply to declare that it cannot be done on individuals who cannot personally consent to it" [7]. This approach has been suggested for the state of South Dakota [19]. It is also the approach taken by Maryland in deciding the 1979 petition [1].

A second approach is to adopt a Quinlan-type decision by "defining the test to be applied in making a decision to sterilize and permitting the family of the incompetent and their physician (with or without the help of a review committee) to make the decision without resort to the courts" [7].[2]

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[2] Annas also notes that there are three good reasons to distinguish involuntary sterilization cases from the Quinlin decision [7, p 19]

A third approach is for individual courts to evaluate cases in which sterilization of a mentally retarded individual is at issue and to authorize it only if it is in the person's "best interests." This, of course, is the approach used in the Grady decision. The fact that this decision and others like it are made on the basis of the best interests of the incompetent person leads me to believe that some courts have found a new justification for authorization of involuntary sterilization: that of paternalism. But is paternalism an adequate justifying principle for infringing the fundamental right to procreate in mentally retarded persons incapable of expressing their own voluntary choices in the matter?

3 Justifying Principles for Involuntary Sterilization of the Mentally Retarded

3.1 Paternalistic Principle

Paternalism is a liberty-limiting principle often invoked to justify state intervention to benefit or to prevent harms to a person. Acting paternalistically involves "over riding a person's wishes, wants, or actions" [12]. Although there is reason to believe that some examples of paternalism are justified, there is also some doubt as to whether paternalism is an acceptable justifying principle for involuntary sterilization of mentally retarded persons.

John Stuart Mill considered paternalism to be unjustified as a liberty-limiting principle, regardless of the conditions [20]. For a person to be justifiably coerced, Mill thought it must be because his actions will do definite damage to others or there is a risk of damage to another individual. For Mill, infringement of personal liberty to protect a person from acts which do not violate public duties nor harm anyone else is not morally justified.

Other theorists, however, have argued against Mill's position claiming that some acts of paternalism are justified if they meet certain necessary conditions. According to Beauchamp and Childress, one condition is that the intervention "would have to avoid an extremely risky circumstance where there are potentially serious and irreversible consequences for the patient, as well as no available alternatives that are likely to be more beneficial" [12, p 162]. Do decisions for involuntary sterilization meet this necessary condition?

I say no. First, the use of the paternalistic principle for involuntary sterilization with mildly and some moderately retarded persons does not avoid an "extremely risky circumstance with potentially serious and irreversible consequences for the patient." Pregnancy and parenthood are not any more risky for the majority of the mildly retarded and some moderately retarded than it is for so-called normal individuals, nor do they entail serious consequences, especially for mildly retarded persons [21-23].[3] Furthermore, there are other alternatives available to mildly and moderately retarded individuals in the form of contraceptive devices. Certainly the use of contraceptives while retaining procreative capacities is of more benefit to

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[3] Anne T. Payne [21] gives a good discussion of how the mentally retarded are stigmatized by laws that have nothing to do with parent/child relations

mildly and some moderately retarded persons than the involuntary loss of a significant and fundamental liberty right.

Thus, if the paternalistic principle cannot be shown to be morally sufficient as a justifying principle to limit the liberty of mildly and some moderately retarded persons, then we must look elsewhere for an adequate justifying principle to support involuntary sterilization.

3.2 Harm Principle

The harm principle justifies coercive interference with a person's liberty where there is reason to believe that his acts will result in physical or mental harm(s) to others, whether or not these actions are within the control of the individual. According to Mill, the only acceptable grounds for interfering with the liberty of actions of persons is to prevent harms from occurring to others [20, p 13]. I support Mill's claim that the harm principle specifies the only valid, moral grounds for intervention of another's liberty. Yet this principle cannot be applied to the mildly mentally retarded for the purpose of sterilization. In order to do so, we would have to consider that the bearing of a child by the mildly mentally retarded person causes harms to others. And this is simply not true. The harm principle can only be applied to some moderately retarded and profoundly and severely mentally retarded persons for the sterilization to be justified. In these classifications of mental retardation, menstruation, pregnancy, or child-bearing would understandably involve significant psychological and physical harms to other persons, such as parents or caretakers. Because mentally retarded persons as well as parents and caretakers may be harmed, the fundamental right to procreate may be justifiably interfered with through involuntary sterilization. Thus, the harm principle allows involuntary sterilization of some retarded individuals when it can be demonstrated that their involuntary actions concerning procreating pose a significant risk of harm to others.

Application of the harm principle is therefore of interest to legislators and courts who must adjudicate petitions for involuntary sterilization of incompetent as well as competent retarded persons. A purpose of any legislation or court decision regarding sterilization is to prevent the abuse of regulations whereby involuntary sterilization can be allowed. Applying best interests standards is largely paternalistic and not morally justified. Thus for legislators, the key to the entire matter is the language used to satisfy substantive and procedural due processes as well as to demonstrate the moral justifications for involuntary sterilization of incompetent persons. Only in so doing can retarded citizens be protected from sterilization abuse for the benefits of others.

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Informed Consent

A. J. Davis

In order to ascertain the role of the nurse in the informed consent process in instances of research and treatment, 45 nurses were interviewed from two settings:

1. A public general hospital and
2. a private medical center.

This study falls into the category of descriptive ethics because it addresses the question of what people actually do rather than what they ought to do. Underlying the interview questions were two larger questions:

1. what do nurses see as their ethical obligation in the informed consent process and
2. how far does this obligation extend?

In most instances nurses have probably not been involved in the original phase of the informed consent process. Therefore, they usually don't know what went on between the physician and the patient or between researcher and the patient. In other words, nurses don't tend to have a formal role in the informed consent process, although they do witness the patient's signature at times.

But patients talk with nurses because they are often more accessible than other members of the health care team. Therefore, nurses have a great deal of important data about the patient, including his or her concerns, fears, lack of knowledge or understanding about his or her situation, etc. For example, suppose a nurse goes into a patient's room and the patient says, "I'm going to surgery, but I really don't understand what's wrong with me and what this surgery is all about, although I signed a piece of paper saying that I did understand and that everything was OK. My doctor told me that this operation is the best thing to do, but I was wondering if there were some other things he could do first which would be less terrible and difficult."

The patient has given the nurse some information that no one else seems to have and which throws into question the informed consent process. The first question confronting this nurse is: Do I have any ethical obligations in this situation? Suppose that she decides that, yes, she does have an ethical obligation to inform the physician and does so. What if the physician says that he thinks it is unnecessary to further explain to the patient, since the situation is very complex and difficult for the patient to understand? The physician then does nothing. Now the second question arises. Has the nurse met her ethical obligation to the patient by going to the physician, although the situation will not change? In short, how far does the nurse's ethical obligation extend? If this nurse believes that she has not met her ethical obligation, then what should she do next?

Some of the major ethical principles in the Western philosophical tradition are: autonomy, nonmaleficence (do no harm), beneficence (do good), justice, and veracity (truth-telling). Although informed consent serves several important functions, its basic function is to safeguard the patient's autonomy. We have a moral duty to seek a valid consent because the consenting party is an autonomous person with all of the entitlements that that status confers. Second-party consent is grounded in the ethical principle of nonmaleficence, and it is appropriate only when the patient cannot speak in his own best interest, such as when the patient is a young child or when he is comatose, etc.

The elements of informed consent are based on the competence of the patient to consent and include disclosure of information by the health professional, comprehension of the information by the patient, and, importantly, the patient's voluntary consent. There has been some research on these aspects of informed consent. I shall mention only a few such studies.

Bradford Gray, a sociologist, interviewed 51 women who were in another study to determine the effects of a new labor-inducing drug. He found that although all 51 women had signed the consent form, 20 did not realize that they were in this drug study. Many did not understand that there was some risk in being in the drug study, and some did not realize that they could have said "no" to participating [1]. This study by Gray points to the potential weaknesses in informed consent, which is the major formal mechanism to safeguard patients' autonomy in instances of research and treatment.

In another study, it has been demonstrated that in order to understand the content of informed consent forms, one needs at least 3 years of education beyond high school [2]. Many patients do not have this much education, so they cannot understand the content in informed consent forms. This shows the extent to which health professionals have difficulty disclosing information in a meaningful way. Such a communication problem is functional in that it maintains the maldistribution of power due to amount of information. In my own experience of several years as a member of an institutional review board, I found the complexity of the consent forms to be a major problem.

One of the problems in informed consent is the reality of paternalism in the health care system. Paternalism occurs when someone else makes your decisions for you in your own best interest, whether you would see it that way or not, provided you had the data on which to make your own decisions. Paternalism violates autonomy, since it reduced adults to the status of young children who cannot decide in their own best interest because they have not developed cognitive skills or moral understanding. To decide for young children is appropriate, but paternalistic behavior toward adults can be ethically justifiable only under limited and special circumstances.

John Stuart Mill, the nineteenth-century English philosopher, wrote:

> The sole end for which mankind are warranted, individually or collectively, in interfering with the liberty of actions of any of their number, is self-protection. He cannot rightfully be compelled to do or forebear because it will be better for him to do so, because it will make him happier, because in the opinion of others to do so would be wise or even right [3].

Essentially, what Mill is saying is that we cannot advance the interests of the individual by compulsion, or if we attempt to do so, the evil involved outweighs the good done.

And yet the health care system tends to be shot through with paternalism. Such behavior on the part of health care professionals makes life easier for them, since they do not have to deal with the consequences of shared information. While paternalism can serve in the immediate best interest of the professionals, it does not respect the patient as a person. The reason we have such documents as the Patient's Bill of Rights is because it is so easy to violate them. In health care ethics we speak of vulnerable populations which include the mentally ill, the mentally retarded, comatose patients, young children, fetuses, etc. But I believe that all patients are potentially vulnerable. These brief remarks on informed consent are focused on only one area of vulnerability.

For us in nursing, there are at least two basic questions:

1. What are the nurse's ethical obligations to the patient in the informed consent process?
2. How far do these obligations extend?

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Issues of Confidentiality in Health Care

L. C. Greif

The purpose of this paper is to examine several questions that arise regarding confidentiality of information. It has been a long-standing principle among physicians, nurses, and other health care professionals that information from or about patients and information from or about colleagues should never be disclosed or discussed. This professional attitude was and is based on tradition, ethics, and law.

There are questions raised among health professionals asking if confidentiality nowadays can be realized and is it truly a must. An argument on this controversial topic could serve as an interesting opening to our discussion but I shall refrain from such an argument because I sincerely believe that confidentiality is *sine qua non* in the health professional patient relationship. It is well rooted in ethics and is governed by law. Revealed information to other parties may lead patients, colleagues, or others to personal, social, or occupational damages.

The issue I wish to raise now is privileged confidentiality. The physicians are protected by privileged confidentiality. They are released from the obligation to testify in a court of law about their patients unless the court orders otherwise; even then the information is being held confidentially from the public.

The role and the status of the nurse has changed enormously - professionally and legally. The patients enter into the nurse-patient relationship in expectation of confidentiality; it is an essential element to the maintenance of their relationship. But the nurse is still not protected by privileged confidentiality that recognizes the unique nurse-patient relationship, though the confidences disclosed to her by the patients are as personal and intimate as those revealed to the physician.

It may be interesting to mention that in the case of *Mississippi Power and Light Co. v Jordan* [1] the court extended privileged confidentiality to a nurse because her duties were performed in a role as an aide to the physician - a kind of extended privileged confidentiality from the doctor to the nurse. That is not our aim. I think that the nurses today have to put their minds to this issue and strive to achieve privileged confidentiality.

Another issue is the professional nurse's autonomy in the domain of health education and giving to the patients information needed for decision making and maintenance of health. Some nurses find it difficult to act appropriately in this autonomous role in spite of their impressive education in nursing and in biological and behavioral sciences. Historical and psychological explanations can be given, but it seems to me that there are two main reasons: first, fear of legal consequences which may result because of autonomous action and second, fear of consequences within the institution. The case of *Tuma* v *Board of Nursing in the State of Idaho* [2] in 1979 can serve as an example of one who took this personal risk. A patient told Jolene Tuma that the physician did not discuss alternative cancer therapies with her. Tuma discussed the prescribed chemotherapy and the alternative treatment with herbs and nutrition with the patient and her family. She did not recommend any specific treatment.

Did the nurse Jolene Tuma exceed the limits of the nursing role or did she just perform her obligation and duty towards the patient? What about the patient's right to know and to give informed consent? The hospital personnel complained that the nurse was interfering with the physician-patient relationship. Her license was suspended for 6 months. This verdict was reversed later by the Supreme Court in Idaho.

I am more than convinced that it is the professional nurse's duty to give patients information needed for maintenance of health and decision making. But the information must be based on well-established communication and collaboration between physician and nurse. Otherwise, our claim that nursing should embrace teaching and giving information to patients will be no less or no more than lip service.

Another issue is raised: how much is one obliged to respect confidentiality in the professional-professional relationship. Years ago the physicians used to enjoy unquestioned support in all their deeds; they were protected by all the staff, including the nurses. Today, the physician is no longer the "captain of the ship" and the nurse is not a "borrowed servant" - professionally and legally. The physicians' and the nurses' primary obligation is to serve the patients and to safeguard them. Therefore, in some situations, reporting to a superior about an incompetent or negligent colleague - be it a nurse or a physician - is obligatory to protect the patient from harm.

But what does a nurse do when the superiors do not act? Does she dare to act on her own? Does she know that she is taking a risk of damaging her relationship with the colleague and others, incurring a possible lawsuit for defamation, and engendering possible unpleasant reactions of the institution, as arose in the case of Rafferty v Philadelphia Psychiatric Center [3]. Linda Rafferty, a psychiatric nurse, reported to her superior about the incompetent care given by the staff to patients over a 5-year period. Because no action was taken she resigned and spoke out publicly against the institution and the staff.

Several days after her employment as a supervisor at another psychiatric center, an article about the conditions in her previous place of work appeared in a newspaper. Linda Rafferty was immediately discharged from her new post. An outspoken nurse was *persona non grata*. She was protected in court because her charges were true, and the aim of her report to the newspaper was in the public's interest.

It must be clear to all that confidentiality and secrecy cannot serve as a cover-up for unethical and unprofessional behavior and for incompetent and negligent patient care. Of course, the nurse has to be loyal to her colleagues and to the institution and voice her opinions through the official channels, but if they fail to act appropriately she has no alternative but to act on her own.

However, it is our duty to strive to secure the nurses' authority to express opinions about the quality of patient care for the benefit of the patient and the public at large.

Another issue connected with confidentiality in the professional-professional relationship are references given to nurses discharged because of incompetent nursing or unethical behavior.

The references often do not mention the reasons for terminating the nurse's employment and do not disclose any uncomplimentary remark. What are the possible reasons for this behavior? I think that the main reasons are: the feeling of breaking confidence and reporting colleagues, the good will to enable the nurse to get a new start, the fear of a lawsuit for defamation, and the unwillingness to admit failing to teach those nurses better nursing. This reasoning is unprofessional and misleading to the prospective employer. Such attitudes must be changed. The superiors must rid themselves of the feeling of conflict and give honest references based on objective facts. The aim of honest references is to protect the public, the prospective institution, and the discharged nurse from potential harm. From the legal point of view it is interesting to know that the Court of Appeals in New Mexico [4] held that when a nurse applicant informs her prospective employer about her prior employment, she has given consent for the prior employer to give the information about her as a nurse. But it must be understood by both institutions - the requesting one and the one providing information - that the information is of a confidential nature and must be privileged and safeguarded.

I shall now refer to the most common breach of confidentiality and that is gossip. The importance of confidentiality is stressed repeatedly in nursing education and in service; the nurses are warned that naïve, well-meant gossiping may cause irreparable and irreversible damage. It may result in a lawsuit and bring disciplinary action upon the nurse.

An example can be given by the case of *Shaw v Glickman* [5]. The lover, wife, and husband were participants in the same psychotherapeutic group. The wife told her husband that she was leaving him because she had someone else. The psychiatric nurse divulged the lover's identity to the husband. The husband shot the lover. The lover recovered and the case was brought to the court.

The astonishing part of this trial was that no issue was made by the court regarding the nurse's breach of confidentiality, though this fact was well known to the court. Why was this so? Was this behavior considered a routine nursing function?

Speaking about group therapy or group education, one must be alert to the issue of confidentiality and secrecy of the group participants. They have no obligations - legal or ethical.

Therefore it may well be an obligation of the professional to inform the participants of this potential risk. He should stress the necessity and importance of not discussing the names and the information revealed by the group participants and the professionals outside the group. Of course, the professionals should be the model of such responsible and confidential behavior.

The law recognizes the professional-patient relationship based on confidence, because the entrusted communication really belongs to the patient and he is only one who can give consent to divulge information.

The application of this obligation may be problematic sometimes: ethical dilemmas and legal questions may arise. The health professional may feel that revealing information will be for the benefit of the patient, the other party, and in the interest of the public.

An extreme but excellent example is the Tarasoff case [6]. A therapist revealed the possible risk of dangerous behavior in a patient to the police. The therapist and the police did not warn the possible victim or her family. The patient promised the police to behave well. But the tragedy occurred and a girl was killed by the patient. The therapist and the police were sued by the family of the victim for not revealing the danger to the victim. In this case the Supreme Court decided that "the special relation that arises between a patient and his doctor or psychotherapist ... may support affirmative duties for the benefit of a third person ..."

In contrast with this case is the aforementioned Shaw case [5]. The Maryland court held that the behavior of the husband did not appear to the therapist to pose a danger to the lover. There was no possible victim to be protected.

According to the law a professional has to behave in a way a reasonably prudent professional would behave in similar situations and under similar circumstances. There are situations and circumstances in which the professional will be legally justified to disclose information received from or about a patient for the benefit of another party and the patient himself. The integrity of the professional-patient relationship can be protected by informing the patient that the information will be revealed and why. Can a breach of confidentiality be morally justified? The variety of life situations are unforeseeable; the code of ethics cannot supply specific answers to specific situations. Each health professional must decide on his path as a responsible ethical person.

Another issue is the health professional acting as double agent. Health professionals are appointed by the government, schools, private agencies, and others to treat their employees and students.

The professional may feel that he has a dual obligation: to the employer and to the patient. The patient is of course expecting confidentiality that is morally and legally due to him, and the employer is expecting to receive a full report about the patient-employee. Even we as directors of schools or nursing services expect to receive reports from the personnel physician. It is doubtful whether the professionals have the fortitude to refuse to communicate information about their patients to the employer or are courageous enough to tell the patients that they may fail in keeping all information regarding their health confidential. The problem of this is even more complicated and problematic when dealing with psychiatric patients.

In case the health professional finds it necessary to reveal some information because of the benefit of the patient or others - as was pointed out in the aforementioned issue - the information must be safeguarded by the rules of qualified privilege.

Another issue I wish to raise is whether a patient should have access to his own medical records in certain circumstances? Has his lawyer access to his client's records - by patient's consent - in case he wants to investigate and make certain the confidentiality is not used as an excuse?

In Israel, patients do not have this right in spite of the theoretically adopted attitude that patients have the right to all information. The lack of the patient's access to his medical records increases suspicion and does not help to clarify the case.

It may as well harm patients when they are under treatment in another hospital or with another physician.

There are some legal and psychological reasons for not wanting to expose records. But the records are about the patient and they really belong to him. I think that the existing approach should be changed and decided upon by various health professionals and by the public and guarded by the law.

One may well define this issue as an international problem because of mobility of people nowadays from country to country.

The last issue I want to mention is computerization in health care.

In some states health information about patients is computerized. In time it will progress and will be in practice in most modern countries.

It seems that the leakage of information will be much greater through the computerized data systems. Questions arise: Who will control those systems? Who will be authorized to have legal access to this data? Will appropriate legislation be able to protect this huge storage?

The problems mentioned here and many many others arising from this issue must be discussed over and over again by health professionals, lawyers, ethicists, computer specialists, and other experts with the aim of implementing administrative, technical, legal, and other safeguards for the computerized health data information system to protect the privacy and confidentiality of the patient and public at large.

The discussions should be based on ongoing studies and researches done by all the different disciplines mentioned above.

Most of the issues I raised now in regard to confidentiality and secrecy, and others that I did not mention, were raised in the past; but they have to be voiced over and over again until satisfactory directions and answers will be found.

It will be a long and painful process!

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Father-Daughter Incest: Who Owns the Child?

M. deChesnay

1 Introduction

Now that the conspiracy of silence about incest has been penetrated, a number of contradictory positions arise. Rights of the father, rights of the child, duties of family members, duties of society, definitions of normality and deviance - all these translate into issues with no easy resolution. When one person's rights conflict with another's, whose take precedence? Who decides? We sometimes get stuck when we try to place rights within a hierarchy. In the case of father-daughter incest, when the daughter is clearly a victim and the father clearly an aggressor, as in infant rape, it may be easy to resolve ethical conflicts or perhaps none arise. However, suppose a teenage daughter contends that she is happy in her incestuous relationship with her father? Maybe no harm appears in their relationship. Then people may ask whether incest is all that bad. Some may say that only the effects are bad. Sometimes.

As a nurse-family therapist who treats families in which incest has occurred, I felt obligated to make some attempt to understand more about fathers' justification for their participation in incest.

1.1 Literature Review

With few exceptions, incest tabus are universal. That is, sexual relations between *culturally defined* family members (within a kinship group) are forbidden. Brother-sister and parent-child tabus are described everywhere. Noteworthy exceptions occurred among ancient Hawaiians, Egyptians, and Incas, where brother-sister marriages were sometimes arranged to preserve the supernatural powers of royalty. Other exceptions were noted among the Balinese in the case of opposite sex twins and when the children were defined as the property of the father (as Leach reported of a tribe in southeast Asia [9]. Penalties ranged from definition of the incestuous couple as crazy by the North American Plains Indians or banishment and humiliation in Bali [9] to death, as in some Australian tribes and the Ashanti of West Africa.

If the incest tabu is universal, then what is going on now in the United States, where over 100,000 cases of incest are reported each year? That is believed to be a conservative estimate of the incidence. Finkelhor [6] estimated that over one million women have participated in incest with their fathers and an additional 16,000 do so each year. Westermarck's biological and instinctual theories have been rejected by contemporary anthropologists, though a revival of interest in them is being expressed in research on primates. The functional-structural theories of Malinowski, Tylor, and Levi-Strauss [11] explain the incest tabu on the basis of the disruptive effect of competition within the kinship group (Malinowski) and the importance of exogamous marital alliances to broaden the scope of social integration - marry out or be killed out (Tylor and Levi-Strauss).

Despite the increase in frequency of articles and books about incest published in the United States within the past 5 years, few of the articles report generalizable research. Notable among the books published by clinicians is Herman's synthesis of the literature and her own clinical interviews [7]. Kathryn Brady [4], Louise Armstrong [3], Maya Angelou [2], and Charlotte Vale Allen have desribed their own experiences as victims of incest. In these books, as well as reported research by Burgess et al. [5], Herman and Hirschman [8], Poznanski and Blos [13], Miller and Mansfield [12], Spencer [14], and Anderson and Shafer [1], power is a dominate theme. Janeway [10] attributed abuse of power in incest to patriarchal prerogative. The notion that fathers can do anything they can get away with to their children is supported by the hesitance of family members to disrupt the stability of the family and by neighbors or public officials who are reluctant to interfere in family matters. Here is where one ethical dilemma lies: the family is sacrosanct, so we don't want to meddle; yet how can we prevent the abuse of family power? Who decides for the child? What if the child appears to choose incest? Does the child really have a say? Is it possible for a child dependent upon the family to have a free, informed choice?

2 Materials and Methods

In order to formulate a guide for practice with incestuous families, a research project was designed to determine how incestuous and nonincestuous fathers and their daughters perceive their rights and duties toward each other. It was hypothesized that incestuous fathers and their daughters would say that fathers would have different rights than nonincestuous fathers and daughters.

2.1 Sample

Sixty pairs of fathers and teenage daughters were interviewed. These were selected into three groups of 20 each: fathers and daughters in family therapy for incest, fathers and daughters in family therapy for other problems, and fathers and daughters not in family or individual therapy. The first two groups were randomly selected from the investigator's case load at least 6 months after treatment was terminated. The third group - fathers and daughters not in therapy - was selected within the practice community. All subjects were informed of the nature and procedures of the research and that their responses would be confidential. It was determined that the study qualified for exemption status for review. Uncontrolled sources of error included the use of one therapist's case load, the nature of self-reported research, the exclusion of other family members' input, and the questionable randomness of the third group.

2.2 Instrumentation and Procedure

A structured interview was conducted with each individual, separately. Each person was asked to answer several questions designed to elicit information about parental and child rights and duties.

Content validity was established by the panel method, but construct validity was not established. The reason is that it is nearly impossible to establish construct validity on the first administration. Criterion-related validity was measured by correlating responses on the rights and duties questions with the criterion of incest participation. The correlation of participation in incest with rights and duties was 0.75. Reliability was measured in several ways. The items were first treated as parallel measures and a reliability of 0.56 was obtained. The split-halves method produced a reliability of 0.86 for the total questionnaire. Finally, Cronbach's alpha was calculated and resulted in an internal consistency score of 0.89. It was concluded that the test was reasonably valid and reliable.

2.3 Data Analysis

Data were analyzed qualitatively and quantitatively. First, a typology of parental rights and duties was constructed. Chi-square tests were performed to test the null hypothesis that there would be no significant difference among the three groups of incestuous pairs, non-incest therapy pairs, and nontherapy pairs. Alpha was set at the 0.05 level. A general linear model was tested to examine the variance in participation in incest. That is, participation in incest was regressed on the demographic variables.

3 Results and Conclusions

3.1 Description of Sample

No significant difference was noted among the three groups of father-daughter pairs on the socioeconomic variables of Amount of Father's Education, Total Annual Family Income, and Father's Occupation. Most fathers had some college education, were employed in technical or nonmanagement jobs, and had a total family income of between $25,000 and $30,000 per year. This income is somewhat misleading because it includes the wife's income, which in some cases exceeded the husband's. Also, some husbands had wives who were unemployed.

Two additional items were measured and both showed high correlations with incest. Incest fathers identified themselves as heads of housholds, whereas nonincest fathers in both other groups tended to say they were joint heads of house with their wives ($r = 0.64$). Incest fathers also tended to use more alcohol than nonincest fathers ($r = 0.59$).

No significant differences were found between the therapy clients and nontherapy clients on any of the items about parental and child rights and duties.

Significant differences were found between the incest fathers' perception of their rights and duties and the other fathers on the following.

Incest fathers said that they had a right

1. To educate their children regarding sex
2. To act as head of house and be obeyed without question
3. To meet their sexual needs with their children

Incest fathers said they had a duty to be faithful to their wives and incest was defined by them as not being unfaithful.

Nonincest fathers perceived that they had a right

1. To determine rules
2. To be respected

Regarding their children's rights, nonincest fathers differed significantly from incest fathers on the child's right to own her own body. Incest fathers perceived that they owned their children.

Nonincest fathers said they had a duty

1. To see that their daughters received appropriate sex education
2. To role model with the mother or other female partner
3. To set and enforce rules with the mother
4. To protect and provide for the family

Daughters engaged in incest perceived their fathers as heads of household and said they feared their fathers, who were to be obeyed without question. Nonincest daughers more often said their mothers were joint heads with their fathers and that their fathers were respected rather than feared. Interestingly, no significant differences were found in comparing daughters' perceptions of their own rights on the following:

1. The child should own her own body
2. Daughters should be protected from harm by parents
3. Children shouldn't have to use sex to bargain with their fathers
4. Children should be socialized into comfortable behavior by their parents

Nearly all the nonincest fathers and none of the incest fathers said these were children's rights.

A general linear model was constructed to predict the variance in participation in incest explained by the demographic characteristics. All demographic variables acting together explained 68% of the variance, but only Head of House and Father's Alcohol Use were significant at the 0.05 level. These two variables explained 62% of the variance. Therefore, the null hypothesis that $R^2 = 0$ was rejected.

From the data, it was concluded that

1. A significant relationship existed between fathers' perception of rights and duties and participation in incest. Fathers who engaged in incest were more likely to justify their behavior on the basis of educating their children about sex, the father's right to be obeyed, and the father's right to meet his own sexual needs. Incest fathers said that they were not being unfaithful to their wives by engaging in incest to meet sexual needs they claimed the wife would not meet. However, 78% of

these men admitted continuing to have sex with their wives and simultaneously having sex with their daughter.

2. Regarding children's rights, the nonincest fathers tended to perceive that children have rights, whereas incest fathers placed their own rights above those of their children.
3. Participation in incest was predicted from knowledge of father's and daughter's perception of father as head of household and alcohol use by the fathers. However, this finding should be interpreted cautiously. Though it is consistent with findings by other researchers, notably Anderson and Shafer [1], no attempt to show linear causality was made. Because of the limitations of my study, I am unwilling to place much emphasis on this finding.

4 Implications

Implications for therapy with father-daughter incest families are that knowledge of family members' perceptions of rights and duties might enable the therapist to gain leverage in order to produce change. Fathers have legitimized authority in rearing their children, but incest represents an encroachment upon the child's rights. The child's right to her body supersedes the father's rights over the child. Fathers who engage in incest with their daughters fail to perform their duty to protect their children and to allow them to choose their own sexual partners freely. Therefore, fathers engaged in incest may need to be confronted on how they place their own rights and privileges above the rights of their daughters. Daughters may need to be helped to learn nonvictim behaviors.

5 Recommendations

1. Admittedly, the investigator started with the bias that the child ultimately owns the child. While precautions were taken to minimize the influence of this bias during the interviews, the study should be replicated. Plans are underway to conduct a similar study by using the self-administered questionnaire method. Access to clients is difficult in incest cases, but it would be valuable for a different interviewer system to be implemented in order to facilitate interrater reliability.

2. Inclusion of other family members in the sample would give a clearer picture of the family dynamics and the influences of the others on the father-daughter pairs.

3. Since no evidence was found to refute the research hypothesis that incest fathers are different from nonincest fathers on the items measured, it seems legitimate to incorporate assessment of perceptions of parental and child rights into family therapy with incestuous families.

4. It would be interesting to ask the same questions about rights and duties of individuals engaged in other forms of incest.

5. The typology of rights and duties should be factor analyzed to assess construct validity.

The notion that the female child owns her own body and that this right of the child supersedes paternal rights is a fairly recent, radical position. The long tradition of *parens patriae* (the father owns his family) is a legacy from the Roman empire. Currently, there are signs that fathers are showing interest in nurturing their children. Too often, though, this new interest is expressed in struggles to reassert patriarchal prerogatives: rights without duties. Male energies to do good things for children are still balanced by power games with women. For example, the United States Jaycees, who spend time and money raising funds for worthy causes (children's hospitals and other), have recently turned back the clock and voted to support male dominance by expelling chapters that refuse to expel their women members.

Abuse of women by men is a logical consequence of patriarchal family structure. Herman [7] says that as long as the power to dominate families is legitimately given to men, then they have the power to abuse their children sexually. Most fathers will choose not to exercise this power; but if one does, it is one too many. The position I take with fathers in family therapy when father-daughter incest is the presenting problem is, first of all, that the child's right to her own body takes precedence over the father's rights to educate his daughter sexually and to meet his own sexual needs. The notion that children may appear to consent to incest fails to justify the father's behavior because children and fathers are not equals. The power distribution is skewed in favor of the father. Children dependent upon their fathers for food, shelter, and the whole of family life are not freely consenting to incest. They are merely submitting to what they see as an inevitable course of action. Fathers who engage in incest with their daughters fail in their duty to act with respect for the child's right to own her own body and to deal with their daughters in ways that enhance growth. Therefore, the first directive is to the father, and that is: The incest must stop at once. If this directive is framed in a way that the whole family can accept, if the mother can be moved closer to the daughter, and if the father can be taught the difference between nurturing and self-indulgend displays of affection, then the potential is good for minimizing the harmful effects on the daughter and promoting the health of the family.

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Prosecutors or Defenders: With Whom Should Clinicians Align?

S. A. Smoyak

There is an apparent, accepted splitting, or the assumption of a natural and expected conflict, between the mental health sciences and ethics - or between mental health and social order or social reform. This division presumes that one cannot "have it both ways" when deciding on whether a given act or behavior is illness or sin. Tender, loving care and moral indignation are polar opposites; one cannot be a therapist and a judge at the same time. When, as a therapist, one works with family systems, as opposed to individual persons in treatment, the question of illness versus sin comes center front when a family member commits a violent act - even murder - against another family member. When the law steps in, where does the therapist step? On whose side does he or she align? With the prosecutor? With the defender? With neither? Is neutrality really possible? Is neutrality useful? Short of homicide, when a family member commits a societally deviant act (robbery, drug dealing, other antisocial acts), what is the stance of the therapist with the family? When the family is struggling over whether to give evidence to the prosecutor or whether to plead for a public defender, how does the therapist act? What does he or she do? What position is taken when parents ask for help in resolving their conflict over extending, to an arrested child, forgiving love versus righteous judgment?

Clinicians, particularly those who work with families, are strangely silent in addressing these questions at conferences or in print. However, they are very much discussed issues in case conferences and clinical staff meetings. Interestingly, while there is passing mention and an occasional article [1] on records of therapists being subpoenaed (or therapists, themselves), there is no systematic treatment of this subject, either.

In the literature, there are several thought-provoking articles on the ethical considerations in serving as an expert witness. The accounts of dilemmas of expert witnesses are "after-the-fact" accounts. The expert is called by the judge, the prosecuting attorney, or the defense lawyer (public defender, perhaps) after a crime has been commited or there is a civil suit in progress. (Parenthetically, the system of justice alluded to in this paper stems from the adversarial two-party method in English jurisprudence. It would be fascinating to compare how other countries handle their mental health and legal systems when they become intertwined.) While there are articles about expert witnesses, there are none describing the situation in which a therapist, working with an entire family, wherein one family member subsequently does violence to another, chooses to align with the offense or the defense in the legal setting. During the past 20 years or so, many more therapists have chosen to work in the family mode. It is surprising, therefore, that there is this gap in the literature concerning their involvement with legal matters involving their clients.

A nurse clinical specialist, who has been working with a family as their therapist, is a very different type of expert witness. Her knowledge of human behavior, interpersonal dynamics, and psychopathology in an academic sense is, under these conditions of clinical involvement with the family, very much enhanced and expanded.

McCormick [2] cited by McCary [3] provides a succinct summary of the qualifications of an expert witness:

> An observer is qualified to testify because he has the first-hand knowledge which the jury does not have of the situation or transaction at issue. The expert has something different to contribute. *This is a power to draw inferences from the facts which a jury would not be competent to draw.* To warrant the use of expert testimony, then, two elements are required. *First, the subject of the inference must be so distinctly related to some science, profession, business, or occupation as to be beyond the ken of average laymen; and second, the witness must have such skill, knowledge, or experience in that field or calling as to make it appear that his opinion or inferences will probably aid the trier of fact in his search for the truth* [2]. (italics mine)

It is generally assumed that it is not enough for a witness to qualify as an expert simply because he or she belongs to a profession to which the subject of the suit is related. The expert witness must show further evidence of his or her special knowledge about these particular matters at hand. This special knowledge may be obtained from clinical practice or experience as well as academic training.

There are many allusions in the literature to the testimony of an expert witness being challenged because the basis of his opinion has been formed in a very short time. For instance, psychiatrists called to testify by a prosecutor frequently spend only an hour or two with the subject, and in some instances rely only on case records and histories. Psychologists, while they tend to take longer performing a battery of tests, also spend relatively little time in forming an opinion. The nurse clinician, then (or any mental health professional who has been serving the client or the family), is in a far better position to help a judge and jury decide what the truth is.

The answer to the question, "With whom should clinicians align in the legal process?" is a most complicated one. At the most abstract level, the answer would be, "With the position that will produce the most good, or the most beneficial results for most of the parties involved, or justice." Of course, each of these ends - good, beneficial results, justice - would need to have operational definitions developed so common understanding would result.

In family contexts (or any human system, for that matter), the obvious problem with the definition of "good" or "justice" is that what is good for one member may not be good for another. One member's voiced rights frequently intrude upon, offend, or violate another member's rights. For instance, a child's right to know, to be informed, or to seek information frequently collides with a parent's right to privacy. In working with families, the skilled and wise therapist attempts to seek solutions to these problems of conflicting rights by moving the system to a new set of rules, wherein both sets of rights are operative, or by establishing rules of the order of turn-taking, boundaries, restructuring alliances, and other system strategies.

In other words, family therapy is framed as changing the system - changing the rules by which the family is governing itself - rather than changing one individual member. The client, in a sense, is the family system rather than the individual family members. The therapist, however, respects and helps the development of each individual member.

The legal system, however, never deals with family systems as such, but focuses on persons. One person is a plaintiff or a defendant. Thus, a therapist must shift gears and rethink "good" or "justice" from the context of what the expert testimony will do to or for the family system in the light of what happens to the identified legal subject.

Clinicians are called to testify in both criminal and civil proceedings. The latter often come to court after lengthy, traumatic, and very hostile within-family wars, such as divorce, custody of children, competency of adults to conduct their affairs, and so on. The remainder of this paper will focus only on criminal cases.

When a family member is charged with a crime, and if the therapist chooses to become involved (or is involved by the court by subpoena), he or she would choose to align with the defender. No amount of mental gymnastics could produce a justifiable case for a therapist to become adversary to a client in a legal setting.

Frequently people who have been charged with criminal acts, who are also mentally ill, are openly or subtly denied due process because the bedrock of our court system, the adversarial process, is side-stepped. Too often (again, because of a lack of systematic data, we cannot say exactly *how* often) prosecutors and defenders agree that a person who has commited a violent crime is mentally ill (or was insane at the point the crime was commited) and therefore cannot be brought to trial as a sane person. In so doing, they have usurped the roles of judge and jury. Unless there is a complaint or question raised by some other person or organization (e.g., a family member, public advocate, mental health association, etc.), the accused person moves from jail to mental hospital, undergoing a subtle transformation from accused to condemned, without due process.

Parenthetically, there are several recent articles focused on a related issue - the reification of psychiatry as a profession. Concern is expressed that in the past too much reliance on psychiatrists' opinions has resulted in a distortion of justice. Gardner claims that there are "faint signs of a movement away from exessive reliance on medical judgments in determining criminal responsibility" [4]. Too much faith in psychiatry has "resulted in a perversion of some of the ideals of criminal law, particularly of the principle that the jury, as the conscience of society, should make the moral determination of criminal responsibility"[4].

When persons charged with criminal acts are also thought to be mentally ill, what follows is a very *ad hoc,* loose, ill-defined sequence of decisions made - all outside the courtroom - of competency or not, illness or not, need for confinement or not, harmfulness to self and others or not, and so on. The deciders are ward physicians in state and county mental hospitals (often not even psychiatrists), expert witnesses called by the judge (almost always psychiatrists), or superintendents of institutions (who, today, might be hospital administrators rather than mental health professionals).

The following case will illustrate the dilemmas when the mental health system and the legal system become interlocked. In an old, very traditional community in New Jersey, there was a highly respected Italian Catholic family. The father was a physician, having conducted his general practice for more than 40 years, and was also active on the school board and in other civic activities. The mother fit the picture of a traditional homemaker, also active with the school and extended family responsibilities. The first child was a son, also a physician. The second was a daughter, who was identified by the family as "the problem". The third child, also a daughter, was a nurse. The "problem child," whom we'll call Rosa, was, at the time, 26 years old, unemployed, and spending most of her time closeted in a third-floor garret bedroom in the family mansion. When I first met her, she was lying on a bare mattress on the floor, covered entirely by quilts, in the attic room where the June heat had produced readings of 94° F, even at 9:00 p.m. My monologue of introduction to her, since she for the first hour said nothing (not even emerging from under the quilts), included my identity ("I'm a nurse"), how I got there ("Your family called me to help"), and my position ("From what I can see, things must be miserable for you. Talk to me, so we can figure out what to do.").

Condensing a long, slow, tedious process into a brief summary yields the following: When Rosa joined her mother and father and siblings around the dining room table on the first floor, it became quite clear that she was the classic signaler of family distress. While she had some very obvious symptoms and had even earned diagnostic labels on previous hospital admissions, such as "paranoid schizophrenic" and "drug-dependent, depression psychosis," she clearly was the truth-sayer in the family. With her inappropriate affect and thought-disordered speech, she was able to name and to describe the various family hypocrisies, shams, and pathologies. These included pseudomutual pacts among the paternalistic extended family, oppression of women in both generations (for instance, her father had forced her to have an abortion, although she was opposed to this), drinking problems in mother and brother, inability of the children to confront the parents, coalitions across generations of both Rosa and mother and Rosa and father (which switched with lightning frequency), and so on.

I identified several family strengths, which were verified by the family: (a) although the "truths" were voiced in a somewhat strange fashion, Rosa had succeeded in getting help for the troubled family; (b) the youngest child (24-year-old RN) seemed able to escape the pathological dynamics in a somewhat easier manner and seek outside resources; and (c) the aging parents (father, 70 years old); mother 61 years old) were at their wits' end and eager for respite.

One of the first goals was to stop *all* medications for Rosa. Among other problems, Rosa was the clear victim of iatrogenic disease. From the time she was a very little girl, her physician father had given her drugs inappropriately. For instance, when she awakened from a bad dream and went to the parental bed, crying in terror, he gave her phenobarbital to get her back to sleep. By the time she was an adolescent, she was helping herself to various psychoactive agents in her father's well-stocked office, which was a part of the family home. When things got out of hand and he felt he could not control her drug use, he hospitalized her. When she protested hospitalization, she was given electroshock "treatments." At several points, when she behaved in a bizarre fashion at home, her father and brother together slipped liquid chlorpromazine into her beverages. When I met her, it was truly impossible to evaluate the nature of any mental illness because of the confounding picture presented by the drug abuse.

After a case consultation within the department of psychiatry, the father agreed to stop all medication, with the one exception of an intramuscular dose of fluphenazine. My clinical judgment is that Rosa perceived that this was a truly different situation now. In the past, her father had threatened to cut off her drug supply and had hidden keys and the drugs, themselves. This time, however, was different. Rosa demanded her daily supply of "uppers"; her father refused. She grabbed a kitchen knife and killed him, stabbing him several times in a tussle which occurred on the street in front of the house.

Dozens of questions about due process, justice, and rights can be generated. Rosa was arrested immediately and placed in the county jail. Her younger sister telephoned me and asked me to come and help; her brother could not be found and her mother was hysterical. During the 40-minute ride to this family's home, I tried to sort out what position I would take and what actions of mine would best serve the various family members' needs. The specific questions that highlight the dilemmas when the legal and mental health systems intertwine are these: Who decides to transfer an arrested person from jail to a mental hospital? (The fact that this murder occurred on a weekend further complicated matters.) Who informs the arrested person of his or her rights? Is there an equivalent Miranda ruling for mental patients? Who decides that the person is "unfit to stand trial"? Who has what information about the series of decisions relating to disposition? What does the patient know? What do the family members know? Who is in charge of telling? Who decides that the patient can be transferred from the tight-security ward for the criminally insane to a less restrictive ward in a mental hospital nearer the patient's home? What is the interaction among the family therapist, the judge, the prosecutor's psychiatrist, the public defender, the ward psychiatrist, and family members?

For all of these questions, the common response is that things proceed in an ad hoc, rather than a predictable, manner. In this particular case, even though I had the closest and most detailed knowledge and understanding of this family's dynamics and Rosa's specific act of violence, my inputs have been treated very (gingerly) hesitantly by the legal sector. The public defender did obtain a signed release of information from Rosa, and I did copy and forward my clinical records to him - but I have no evidence that this has made any difference in the decisions made to date. I have visited Rosa in the criminal ward and have had joint (with the ward psychiatrist) and individual sessions with her. How the content of these sessions will be used in court - if she ever comes to trial - is impossible to say.

At this time, the mother is in another mental hospital, voluntarily admitted to intervene in her problem drinking. I have had two family sessions in that hospital - with the adult children (not Rosa, of course), that psychiatrist, and an alcoholism rehabilitation counselor. My attempts to get the total family together for a future planning session have been unsuccessful. The roadblocks are both in the area of Rosa's present legal status and in the fact that the private hospital staff is largely disinclined to physically move themselves to the state hospital for a session.

In this instance, then, the clinician's prior knowledge of facts and events and her prior diagnosis of family pathology could be indispensable to legal truth-seekers. The ambiguity of the actual disposition, however, reflected in the questions I laid out above, have prevented open, clear, rational decision making.

In another murder case, which ironically is proceeding much more straightforwardly, I am the prosecutor's witness. In this case, a woman killed her husband by stabbing him in the back several times as he was leaving his mother-in-law's home. My decision to align with the prosecutor was made on the basis of my review of the arrest record, the interviews of the defendant recorded by others, my interview with a clergyman who knew the couple, and my knowledge about battered women. It was my judgment that this woman's defense that she was a battered woman was not substantiated by the recorded data. Ironically, my testimony is sought after much more enthusiastically in this instance than in the other, although here I am an after-the-fact witness.

In conclusion, the activites of mental health professionals in the legal sector have received considerable attention in the literature. Their usefulness and the relevance of behavioral science information and the testimony of expert witnesses have been widely debated [5]. Ethicists raise questions about their impartiality or objectivity. My position is that the most useful expert witness is one who has prior clinical knowledge of the situation. One may label this "bias"; I prefer to see it as expanded awareness. Diamond has also expressed disbelief that witnesses can actually be neutral or impartial experts. He states:

> It is a fiction of the law that only the immediate parties to a legal action - the defendant and the plaintiff or prosecutor and their counsel - are adversaries. All else: the judge, the jury, and the witnesses, are not to be partisans. All witnesses, both expert and lay witnesses of fact, are sworn to tell the truth, the whole truth, and nothing but the truth. This truth, as revealed in the testimony of the witness, may favor one or the other side, but the witness may not. That this is a fiction, not a reality, is evidenced by the customary manner of labeling witnesses as *for* the defendant or *for* the prosecution.
>
> I will thus concede at the outset that the expert witness called by either adversary is likely to be biased to some degree, that his opinions are not truly impartial, and that he, himself, as a party to the adversary system, becomes to a certain degree an advocate. I concede this with full awareness that both legal and medical codes of ethics demand the impartiality of the expert witness, irrespective of the side that calls him. The desirability of such an ethical ideal must not blind us to the reality fact that the ideal is seldom, if ever, achieved [6].

Given that mental health professionals do become involved with the legal system, the following guidelines are offered in the spirit of keeping honesty a chief operative value.

1. Examine your conscience. Toward what end do you see your energies being expended? To protect your patient's rights or to gather personal fame and fortune?
2. Carefully track the exposition of facts and the sequence of events. What was your clinical opinion at what point in time? Do you detect subtle changes in your thinking as the case unfolds?
3. Be committed to ongoing peer review. Have you used a clinical case conference or "rounds" to expand your thinking? Have you sought inputs of differing perspectives and opinions? Have you shared your thoughts and experiences in published form?

In sum, since neutrality is not possible when the mental health and the legal systems become intertwined, then honesty is the value to be espoused. Clinicians must commit themselves to an ongoing process of both soul-searching and cognitive expansion.

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III. Nursing: Ethical Aspects

Introduction

The papers that make up this section on the ethical aspects of nursing can be divided into five parts:

1. Moral dilemmas in nursing
2. Ethics in educating
3. Nursing research and ethics
4. Ethical decision making
5. Ethics and treatment

In order to ensure adequate, professional nursing treatment for patients, are ethical standards and professional judgment sufficient? Or, are regulations necessary? Legislating codes of conduct may be beneficial as well as an impediment. Add to this moral dilemmas - dilemmas that are implicit in all the helping professions - and we are faced with a possible philosophical impasse.

Given the capacity for choice, moral/ethical conflicts are inevitable. Can we educate nurses to be ethical? Are there specific teaching strategies that can be employed in order to inculcate nurses with an ethical posture? Are ethics learned on the job or in a theoretical manner? Are ethics born or bred - the old nature versus nurture controversy.

The ethical issue becomes more pronounced when dealing with nursing research. The subject, agency, and researcher must be protected: is this possible practically? What about the ethical orientation of the researcher; this may affect research guideline principles and possibly create potential problems. The type of research (interviewing, participant observation, ethnographic, etc.) may also determine whether there will be an ethical conflict. The field of nursing research does have its potential problems, and these must be thoroughly explored in order to minimize the inevitable conflict areas.

Decision making is intricately bound up with the issue of accountability. Responsibility brings with it rights and obligations - to patient, self, and society. The authority-autonomy dimension has an impact here in order to insure a responsible choice. So, too, do the social and role constraints that are imposed on individual nurses. This *must* affect the ethical decision-making process. Ethical role models and simulation games are two of the possible avenues suggested for raising the level of moral judgment.

In the ethics and treatment part of this section, the ultimate philosophical purpose of nursing is examined. Quality of care, treating terminally ill patients, euthanasia, care of the elderly, and death and dignity are some of the issues explored. The countertransference reactions of nursing staff are also related to.

This section on the ethical aspects of nursing includes contributions from Canada, England, Israel, Norway, Scotland, Spain, Sweden, and the United States.

Moral Dilemmas

Moral Dilemmas in Nursing

A. V. Campbell

1 Introduction

George Bernard Shaw, in his biting, yet perceptive, preface to *The Doctor's Dilemma,* had this to say about the medical conscience:

> Doctors are just like other Englishmen: most of them have no honour and no conscience; what they mistake for these is sentimentality and an intense dread of doing anything everybody else does not do ... [1, p 229]

In that same preface GBS made the often-quoted remark that "all professions are ... conspiracies against the laity" [I, p 236]. Now, far be it from me, a mere Scotsman, to make any comment on an Irishman's assessment of the morality of the English! Much more interesting is Shaw's suggestion that medical ethics may be empty convention at best, and, at worst, a kind of humbug designed to conceal the profession's shortcomings from the public. Eliot Freidson makes a similar point, though rather less elegantly: "... a code of ethics may be seen as one of many methods an occupation may use to induce general belief in the ethicality of its members, without *necessarily* bearing directly on individual ethicality" [2].

Might such suspicions be harbored about nursing ethics? Are they the product of that "last temptation" described by T. S. Eliot, "To do the right deed for the wrong reason" [3]? In this paper, I shall look very briefly at this question by observing changes in the character of published codes of nursing ethics in recent times. In particular I shall compare the 1973 version of the International Council of Nurses (ICN) code[1] with the 1965 version[2] (itself a revision of the first ICN code, adopted in 1953). I shall also refer to two national ethical codes: the American Nurses Association (ANA) *Code for Nurses* (1976) [4] and the Royal College of Nursing of the United Kingdom (RCN) *Code of Professional Conduct* [5]. My purpose will be to assess the adequacy of these codes as statements of disinterested moral concern for human well-being by looking at the way they describe professional responsibility. In a short concluding section I shall suggest ways in which the "conspiratorial" character of professionalism might be avoided, not merely by redrafting codes but by changing styles of professional education and practice.

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[1] Adopted by the Grand Council of the International Council of Nurses (ICN) meeting in Frankfurt, Germany, June 1965

[2] Adopted by the ICN Council of National representatives in Mexico City in May 1973

2 Professional Responsibility

The 1973 version of the ICN code differs from the earlier versions in two important respects:

1. Phrases like "belief in the preservation of human life" and the "fundamental responsibility to conserve life" are replaced by "respect for life" and "the responsibility to prevent illness and restore health" and
2. references to carrying out physicians' orders are removed and a new stress on the nurse's own professional judgment is introduced.

To some extent both of these changes seem to reflect the increasing desire to see nursing as a profession in its own right, rather than in the "handmaiden" role to medicine, in the Florence Nightingale tradition. The deletion of any reference to doctor's orders makes an interesting contrast with the following extract from the British Red Cross Society's *Nursing Catechism* [6] - a little family heirloom of mine!

Q. What is the Nurse's duty to the Medical Officer?
A. Absolute loyalty, prompt obedience, and quickness in observing and reporting any change in the patient's condition.

Equally, the move away from an *absolute* responsibility to conserve life to respect for life and responsibility for prevention of and recovery from illness gives the nurse a much more active function in health care. (The phrase "respect for life" echoes the change in the medical ethical codes from the prohibition of abortion and euthanasia of the Hippocratic Oath to the broader phrase "the utmost respect for human life from the time of conception" of the World Medical Association Geneva Convention Code of 1949). Both in relation to the doctor and in relation to the patient, the nurse is being encouraged to a greater exercise of independent professional judgment.

But now the question must be asked: Is this increase in professional responsibility an improvement in the *morality* of nursing practice? Are we seeing here anything more than the hardening up of yet another conspiracy against the laity? In this context the codes of the ANA and the RCN make very interesting reading. Both of these codes have a marked emphasis at the very beginning of their statements on the autonomy of patients or clients. The formulations they use are worth quoting in full. The RCN code states:

> Nursing care should be directed towards the preservation, or restoration, as far as is possible, of a person's ability to function normally and independently within his own chosen environment [5, II, 1].

The ANA code, speaking of the "self-determination of clients" states:

> Each client has the moral right to determine what will be done with his/her person; to be given the information necessary for making informed judgments; to be told the possible effects of care; and to accept, refuse, or terminate, treatment [7].

Both codes also recognize the difficulties in such an emphasis on patient/client autonomy. The RCN code discusses problems in coping with violent patients and the ANA code mentions situations in which individual rights to self-determination may "temporarily be altered for the common good." Nevertheless the emphasis remains striking. In such formulations the self-limiting nature of professionalism is given prominence. Control is handed back, as fully and quickly as possible, to the person receiving nursing care. It is not (apparently) monopolized by the profession by the usual strategy of hiding behind the "medical mystique."

Thus we see an important tension between professional autonomy and patient/client autonomy. Which of these two values does the increasingly self-reliant profession of nursing truly seek to serve? Can it serve them both at once? In considering this, we need to step back for a moment from the specifics of nursing ethics to more general issues of the nature of moral theory.

Morality can be distinguished from mere social convention only if, and when, it attempts to transcend partisan interests. A morality which simply underwrites the power of the stronger over the weaker is no morality at all, but merely (as Shaw observed) a conspiracy. Another way of putting this point is to say that *disinterestedness* is the essence of morality. (This was well observed by Emmanuel Kant when he described "universalizability" as the distinctive feature of moral law.[3]) To expouse a moral principle is to regard some actions as right, whether or not they work to one's own personal advantage or to the advantage of a group of which one is a member. Of course, at a practical level, total disinterestedness is rarely possible and perhaps not even desirable, since it could result in very cold, emotionless relationships. But still the avoidance of bias and partisanship must be been as the fundamental *aim* of morality.[4]

Returning now to professional ethics - and codes of nursing ethics in particular - we can see the difficulty of assessing their moral worth. Although such codes use high-sounding phrases like "service to mankind" (ICN code, 1965) and "respect for dignity and rights" (ICN code, 1973), there is surely no denying that they are also formulated to serve partisan interests. Baldly stated, they are the attempts of a profession to say to the public "you can trust us" and to other professions "give us the respect we deserve." Moreover, professions like medicine and nursing are occupations which make money out of people's misfortune. There is profit in being trusted as a healer and helper. ("There's gold in them thar ills," as Tom Lehrer put it in "The Ballad of Sigmund Freud".) Certainly it would be surprising if any one entered nursing with dreams of riches, given the very modest salary levels which the profession commands, but nonetheless being seen as morally trustworthy *is* an element in ensuring the livelihood of the professional nurse.

Thus if nursing is to be seen as a moral enterprise, not only a way of making money and of gaining social status, it is essential that the aims to which it is committed can be shown to possess independent moral worth. Take as an example the formulations of the 1973 ICN code: "promote health, prevent illness, restore health, alleviate suffering." These are more than empty rhetoric *only if* nursing skills can achieve them. Nursing will achieve them if it is genuinely on the patient's side, arguing against all that is health-denying. This may well mean controversy and debate

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[3] For an exposition of Kant in relation to medical ethics see Campbell [8]

[4] Not all ethical theorists would agree with these views, of course. Some (the ethical egoists) argue that personal advantage in the only possible goal and others (the utilitarians) that the benefit of the majority must be normative

with other professions and with sociopolitical forces. The professional skill of nursing may help the patient regain control of his/her own disordered body and/or mind and emotions, may help with coping with disability so that it ceases to be a handicap, may help in controlling or transcending pain and anxiety and in facing unavoidable death with full awareness and with peace of mind. The nursing profession will deserve respect and trust only to the extent that its search for independent responsibility has such disinterested achievements for the patient in view. It must show that a gain in autonomy for the profession is also a gain in autonomy for those who seek its help.

9 Ethics in Practice

By way of illustration of what I have been saying, I will conclude with a short case illustration. The case is taken from *Dilemmas of Dying*, edited by I. E. Thompson [9]. Like so many such illustrations it is, I fear, an object lesson in what should *not* be done.

> *Death of a Schoolboy*
> David, a schoolboy of 13 years, was the only child of middle-aged parents. One day he was severely injured in the spine as the result of a playground accident at school. When admitted to a paediatric neurosurgical unit it became quickly evident that the damage to the spine was so extensive that David would almost certainly be totally paralysed from the neck down. The boy was fully conscious and obviously very anxious about his condition. After a few hours, his breathing deteriorated rapidly and it became necessary to put him onto a respirator, after performing a tracheostomy under local anaesthetic. At this point David's parents approached the Consultant and asked whether there was any hope of David avoiding total paralysis. They were told that there was virtually none. They then suggested that no further effort should be made to maintain David's life, because they regarded his condition as one which the boy could never tolerate.
>
> The medical staff were surprised by this request but eventually agreed that David should be taken off antibiotics and given increased sedation. However, the night nurse on duty that night withheld the medication because she was opposed on conscientious grounds to giving sedation unnecessarily. At the request of the consultant, this nurse was removed from the case and the regimen was continued.
>
> At no point was the boy told what was happening to him or what his true condition was, and when he asked a nurse if he was dying this was vehemently denied. After about a day or so he died of respiratory failure.[5]

Much could be said about what was wrong in this case, but I will restrict my comments to three points regarding autonomy:

1. David's loss of autonomy from the accident was compounded by the actions and attitudes of the parents and the professional staff; he was deceived, sedated out of awareness, and hastened to death to satisfy other people's judgments of what was best for him.

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[5] Based on a case reported in Thompson [9]

2. The nurse who refused to cooperate in this was simply removed by medical authority, without, it seems, her protest having any effect.
3. The professional staff surrendered their professional autonomy to the *parents*, acceding to their request as though *they* were the patient to whom they owed service.

The case illustrates well the potential future significance of a more articulate and morally educated nursing profession. Conscientious objection by a nurse should lead to a proper debate about the morality of the procedures being carried out, and professionals who are willing to treat individuals as objects to be manipulated (with whatever good intentions) should be open to radical challenge by their colleagues. If the codes of nursing ethics genuinely mean what they appear to say, then a first priority in nurse education would have to be an intensive and sustained exposure to moral education. Awareness of the patient's own self-understanding, ability to criticize set routines, and articulateness in voicing objections to the decisions of others would become skills of equal importance to the many now included in training. If nurses aspire to be moral advocates on their patients' behalf, not simply instruments of medical decision making, then they must learn at least something of the art of both moralist and advocate. Otherwise the claim to a professional autonomy based on disinterested moral commitment to patients *is* just rhetoric.

Earlier in this paper I quoted some words from T. S. Eliot's *Murder in the Cathedral.* I would like to end with some more mysterious words, from his *Four Quartets* [10]. These words suggest, in paradoxical fashion, that a nurse who was fully concerned with the health of people could well feel a stranger in a too-simple world of tranquilized anxiety and scientific medical cure:

> Our only health is the disease
> If we obey the dying nurse
> Whose constant care is not to please
> But to remind of our, and Adam's curse,
> And that, to be restored, our sickness must grow worse.

You will, I hope, forgive so enigmatic an ending. The theologian will out!

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Law or Ethics: Which of Them Should Regulate Nursing Practice?

I. H. Haugen

There seems to be general agreement upon the necessity of some steering mechanisms in the health field and for a system regulating the practice performed by health personnel. The two main reasons for this need are:

1. To secure the patient's safety and
2. to provide status for the health professions.

In this paper different ways for controlling practioners will be discussed. "Laws and regulations" will be used synonymously with "legislation".

In most countries there exist similar laws and regulations which regulate planning, financing, and administrative responsibilities of the health services. The existing legislation concerning nursing and medical practice shows, however, great variation from one country to another. The differences may be due to variations in religion, culture, and political systems, but also countries with great similarities have different systems for regulating the practice of the health professions.

For instance, the World Health Organization's Report on Legislation Concerning Nursing/Midwifery Services and Education shows the differences within the European region [1].

In most countries in the region nursing practice and titles are restricted to holders of the appropriate diploma. In addition a nurse, in the same way as a physician, has to obtain a license or have her diploma registered. The license to practice or a nurse's registration can be withdrawn under conditions specified in legislation. Professional misconduct, gross incompetance, abuse of dependence-producing drugs, alcoholism, physical or mental impairment, or criminal offenses are the most common reasons for withdrawal of the license or registration. In case of malpractice the nurse may even be brought before the court. Under which conditions this may be happen is, however, not the subject of this paper. In the European region most countries also have listed functions and duties which nurses are competent and allowed to perform. The purpose of these lists is to prevent nurses from performing activities which may hurt or injure the patients.

There are no lists of duties or functions which the nurses are obliged to perform for the safety of the patient. Lists of activities which physicians are allowed and competent to perform are not known to exist (at least not the same extent). Thus it seems that as far as physicians are concerned, the practitioner's own judgment about personal competence is accepted by the lawmakers. This acceptance is not true when it comes to the practice of the nursing profession.

This is also the situation in many countries in other parts of the world. Studying the definitions and the lists of functions and duties which express the legal status of the nurse would probably be very provocative reading. The lists of duties are usually exhaustive and consist of detailed technical procedures and activities which a nurse is allowed to perform alone, under a physicians prescription, or sometimes only in his presence. The duties are presented both positively and negatively, i.e., both the activities which a nurse is authorized to perform and the forbidden acts are listed. One characteristic worth mentioning is that in legislation with detailed provisions, including exhaustive lists of duties and functions, nurses are more explicitly placed as assistants to physicians than in less specific provisions.

In all countries physicians are responsible for the medical diagnosis and prescription of treatment. The nurses may, however, be the ones who implement the treatment ordered, including the observations of the patient. It has not yet been accepted in the legislation that these two tasks are mutually interdependent and are of equal importance to the patient. Rarely is the independant *care* concept of nursing, which is much more than technical implementation of ordered treatment, expressed in any legislation.

In some countries there seems to be an increasing tendency to regulate in more and more detail the professional practice of nurses by laws and regulations. The making of these regulations is often initiated by physicians and, more often than not, supported by the nurses and their professional organizations.

However, it is known from experience that the more exhaustive and detailed such regulations are made, the more problems seem to be created. As it is stated in the aforementioned WHO report: "The definition of a nurse and the precise listing of a nurse's duties and functions seem to be questions difficult to answer for lawmakers." The problems arise from the fact that there always will be patients for whom the regulations don't fit and situations were the legal rules cannot be practiced. Another observation worth mentioning is that detailed lists of functions which legally can be performed by nurses have a tendency to be very technical and medically oriented, particularily when the purpose is to clarify which of the physician's activities a nurse can be allowed to execute. The care concept, which is the fundamental aspect of nursing, is an activity standing on its own feet. In all societies there are needs for nursing care which may or may not be connected to medical treatment.

In the future with increasing groups of elderly and handicapped persons and with a complexity of problems, the service delivered should more often be based on nursing judgment than on medical diagnosis.

This genuine concept of nursing may have difficulties to function and make progress because technical procedures and tasks inherited from the medical profession dominate the legal rules. Thus the legislation can easily function as a constraint for further development and be an obstacle for the nursing profession.

In the report from the second liaison meeting with nursing/midwifery associations on WHO's European Nursing/Midwifery Program the following remarks exists: "The constraints placed on the development of nursing care services of high quality... by current legislation was a recurrent theme...." And "legislation and/or regulations regarding health services ... hamper the implemention of needed change" [2].

In some countries very few regulations regarding the practice of the health professions, in general, exist. There is, for instance, not even an attempt made to draw a line between the duties and functions of a physician and those of a nurse. Nevertheless, in these countries fewer problems seem to exist regarding these questions than in countries with more detailed legal regulation. What is now said, however, does not mean that legislation is not wanted or needed. A sound and appropriate nursing legislation is both necessary and desired. In fact, it is a prerequisite for nursing progress.

In the WHO report on legislation it is stated: "Very few countries in the WHO indeed have consolidated nursing laws and rules. The numerous legislative references demonstrate the need for regular consolidation of nursing legislation in the European countries, and this would certainly be welcome on national and international levels." The legislation in this field seems to have developed rather casually, and without a national policy to the question.

If you ask why one specific system for regulating nursing practice is preferred, or to what extent, and why it is desirable to regulate health professionals practice by law, your question may not be answered. This is why we need a broad discussion about the principles on these questions.

Let us then look at some other steering mechanisms in the health field and systems regulating the practice of health workers. Apart from legislation, two main factors are working together in a steering system. The first one is the *ethical* standards of the professions. The professional ethics include attitudes toward individuals, such as confidence, respect, human consideration, compassion, and general attitudes toward life. Due to tradition, ethics is often connected with Christianity and charity. Nurses in particular have in recent years, as part of the struggle for independence, tried to distance themselves as a profession from religion, and therefore meant that ethical rules should be embedded in, or replaced by, laws and regulations.

Few other, if any, services are so dependent on ethical standards as the health field, and the ethics of the nursing and medical professions are as old as the services themselves.

Let us, as an illustration, concentrate on confidence and the influence of this ethical concept in the health field. Confidence between the persons involved is essential. It is an assumption that everybody can trust everyone: the observations are correct, the information is exact, and the instructions are performed or forwarded.

Information is often given orally; this shows the extent of the confidence. Without trust as part of professional ethics, the health care system probably would collapse.

Nurses and physicians traditionally have well-developed ethical standards.

Some of the ethical rules are now embedded in legislation. One example is professional secrecy. Professional secrecy also exemplifics how legislation and ethical rules can be in harmony, and not in conflict with each other.

However, just a few legal provisions exist on the ethics of the nursing profession.

The ethical standards are more often controlled by the profession itself, and the professional organizations usually operate a consultative service for the membership and the society. The organizations may also have the power to take disciplinary actions, i. e., to exclude from membership those who break the ethical rules.

The other important factor in the steering system is the professional judgment of the practitioners. Nursing and medical decisions made by nurses and physicians are all of great importance to the patients. The basis for these decisions is professional judgment, which again is built on knowledge and experience. From an ideal point of view, such decisions should be taken solely to benefit the actual patient. In order to do so, you have to have a flexible system for decision making, based on professional judgment and ethical rules.

Professional judgment and ethical rules are linked closely together. They very often overlap each other and can sometimes hardly be separated. Together they form what we call professional *competence*. The way we take care of a patient with a decubitus ulcer will, for instance demonstrate them both: our professional judgment in the choice of the method used, and our ethical standards expressed through concern, attitude, and priority given to this patient.

In conclusion, in order to secure the patient's life and health the practice of health personnel has to be regulated. Practice is regulated by law through a system of licensing: those who possess the required qualifications are licensed. The possibility of withdrawal of the license to practice in case of malpractice should be sufficient for this purpose.

If professional judgment and ethical standards are good enough, laws and regulations should just frame the basic principles and not be too detailed and specific. Legislation and jurisprudence will never be a good alternative to professional competence. Flexible legislation is also the best tool for improving nursing practice, while too detailed provisions can lead to stagnation. In countries with a well-developed health care system and high ethical and professional standards of nursing service, a legal frame for nursing practice which is broad enough for further development should be preferred.

The question asked in our title was law *or* ethics: which of them should regulate nursing practice? The answer, in short, is neither one nor the other exclusively. We certainly need both law *and* ethics in nursing practice.

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Education

Should Nurses Study Ethics?

J. B. Thompson and H. O. Thompson

1 Introduction

For many people, the question of whether or not nurses should study ethics remains open. One obvious evidence is that we do not yet have ethics taught in all schools of nursing. Some teach it but it is not strongly emphasized. Some frankly say that the answer to this question is no. The reason may be simply one of curriculum. The schedule is already too crowded. With the knowledge explosion, there is already more to teach than students can possibly have time to study.

Other negative responses turn on the belief that nurses do not make decisions: they just follow orders. Even where there is a team approach to health care, the physician is often seen as, or claimed to be, the "captain of the ship."[1] We see this clearly in the 1929 *Catechism for Nurses* quoted by Dr. Campbell with its rule for absolute loyalty (read "obedience") to the physician.

This attitude was widespread in the pre-1940s. The Nuremberg and subsequent trials of war criminals after World War II often brought forth the defense that they were only following orders. This defense was rejected. This excuse is no longer acceptable in our world. Nurses are no longer shielded by, nor can they hide behind, the defense that they are only following orders. In some countries, the courts are still in the pre-1940s, but they are beginning to catch up. Nurses are being held responsible and their responsibility is being recognized [1-3].

This situation is a mixed blessing. Some people do not want responsibility. Following Lowental's psychiatric perspective, we can note that in growing up, adults take on responsibility (Chap. 5). The adolescent wants privileges without responsibility. There's a sense in which nursing is still growing up or growing toward being a profession. Nursing is and is not a profession. It is in the process of becoming a profession. What this means is that individual nurses stand on a spectrum. Many have long since become professionals in the fullest sense of the word. Others are not, and probably never will be, professionals, while others stand somewhere in between [4, 5].

There are those who say that nurses do not need to study ethics because, while they do not officially make decisions, they can always get what they want through covert decisions. It is simply a matter of not letting "daddy" know what is going on. It is a pattern familiar to the dominated who quietly do what they have to or need to

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[1] This concept appears in a "Joint statement of practice relationships between obstetricians and gynecologists and certified nurse-midwives," where we find the words. "The maternity care team should be directed by a qualified obstetrician/gynecologist."

do without stirring up any fuss. One could suggest that this is in itself an ethical situation, or that for this very reason nurses most definitely should study ethics for they are indeed making decisions.

Our answer to the title question is yes, nurses should study ethics. Part of this is based on Jacques Barzun's suggestion that the very nature of human relationship is moral [6]. This thought is echoed by Paul Ramsey as quoted by Sister Simone Roach (Chap. 29). We would extend this to the nature of the human. Robinson Crusoe was a moral being with or without Friday. There is no comment here on the content of the moral. A moral or a person's morals may be good, bad, or indifferent. It is a matter of the standard of judgment one might use. The point here is that to be human is to be moral. The amoral person is classified as a psychopath or sociopath. Here, take note, we are not limiting ethics or morals in nursing to the making of decisions, covert or overt. It is a matter of being. This "is + ness" might be considered under what Anne Davis has called descriptive ethics, that which is (Chap. 12).[2]

In our work, we have found it useful to use the term morals as the shoulds or the oughts of life, what Davis has called normative ethics. This is Henry D. Aiken's level two of moral discourse, as outlined by Sister Roach. Aiken's level three on ethical principles comes close to our use of the term ethics. We see ethics as the philosophical question, "Why?" The ethical concern is to understand why we hold or practice a given moral standard. Ethics is an effort to understand.

Nursing comes in here in its professional role. One could say that anyone could be a nurse. We could take someone off the street and give him or her the task of nursing. The contrast with the professional nurse, however, is profound. The professional nurse by contrast, knows what she/he is doing. This knowledge is not just a memorized list of data, though it certainly includes data about health and illness care. This knowledge is a much deeper kind of understanding. It is understanding why (S. Pollock, personal communication).[3]

We note in passing that it is desirable to be able to articulate the why of ethics in order to communicate it in a cognitive way. Davis noted the importance of this articulation and we agree. Murphy commented on the distinction between the cognitive and the affective. The cognitive is crucial for communication and for the preservation of knowledge. But we would emphasize here that understanding involves both the affective and cognitive [13].[4] In the deepest sense, the one who understands knows what she/he is doing. The ethical why involves this level of understanding.

It is in this sense that we agree with the aphorism that "to be professional is to be ethical: to be unprofessional is to be unethical" (D. G. Jones, personal communication).[5]

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[2] Structural ethics talks about the deep structures with which we are born. The concept of the good and the innate feeling that we must obey moral codes are examples of deep structures. See George H. Kieffer [7], George E. Pugh [8], Gunther S. Stent [9]. The work of Lawrence Kohlberg [10] is prominent in this concern. See also Brenda Mundsey [11] and Lande and Slade [12]

[3] Dr. Solomon Pollock, University of Pennsylvania, once distinguished between a technician and a professional. The technician knows what he/she is doing. The professional understands why

[4] She notes that if we did not have some interest, some sense of value, i. e., affective concern, we simply would not bother with the cognitive

[5] Dr. Donald G. Jones, Drew University, noted this in the area of business ethics. It has wide-ranging implications for all professionals

Take note once again that this does not tell us about the content of the ethical. To be sure, to understand is also to know in the traditional sense. Nurses should study ethics and in that study is included the various approaches to ethics and the nature of ethics. Nurses need a working knowledge of deontology (rules), utilitarian or teleological (ends) ethics, the philosophical approach in general, the theological approach, natural law, the social science approaches of psychology or sociology or anthropology. That is another paper, however. Here we turn to the teaching of ethics. If nurses should study ethics, how do we teach ethics?

2 Teaching Strategies in Ethics

When one begins to think about how to teach ethics for nurses and other health professionals, one considers the objectives and resultant content, the expertise of the faculty, the nature of the audience (level and type of student), and the amount of time that is available for the teaching/learning efforts. Each of these factors will determine the what, who, and how ethics in nursing is taught. In the next few paragraphs, we would like to offer some examples of each of these factors in the teaching of bioethics from our experience during the past 7 years of team teaching with nurses, medical students, and other health-related professionals.

2.1 Purpose and Objectives

The overall purpose of teaching ethics for nurses will determine the objectives one uses for content. There are at least three major purposes of ethics teaching in nursing: (a) to prepare a nurse-ethicist; (b) to prepare students in nursing formally to understand what is ethics, what are the ethical dimensions of practice, and how does one make ethical decisions in practice; and (c) to sensitize nurses (short-term basis) to the topic of ethics and ethical decision making in practice, education, and administration.

The first purpose, that of preparing a nurse-ethicist, involves long-term study, such as a doctoral program or post-doctoral fellowship (e.g., Kennedy scholars). We will not discuss this level of preparation in this paper. The majority of our team-teaching efforts have dealt with formal courses in ethics (the second purpose) and short-term sensitization (the third purpose) efforts in the classroom with a variety of learners. The major objectives we use for formal as well as continuing education efforts include the following:

1. Define and discuss common ethical theories as applied to decisions about health/illness care
2. Define and discuss ethical principles of autonomy, informed consent, beneficence, nonmaleficence, justice, truth-telling, and the concepts of allocation of resources and professional accountability
3. Define and discuss values and values clarification
4. Identify and use a reasoned decision-making process in examining actual case studies in medical and nursing practice

2.2 *Content and Methods*

Given the objectives chosen for teaching ethics, one then needs to formulate the actual content to be included and how that content will be taught and learned. We have successfully divided the time alloted for teaching between formal lecture and practical case analysis in small groups. Here are some examples from our teaching experiences.

One semester we taught an interdisciplinary course (14 weeks) in ethics, law, biomedical technology, and health/illness care. The faculty consisted of a lawyer, a biomedical engineer, an ethicist, and a health professional. We took the first four class periods of 3 hours each for each faculty member to provide the theoretical basis for the course in his particular field of expertise. The rest of the class consisted of having small groups of ten students each work 1-1.5 hours with a specific case and guidelines for discussion, and then return to the large classroom to share the results of their discussion with the total group. This way we could cover many different cases during the semester, and the total group could benefit from the deliberations of the small groups. Faculty also participated in small groups on a consultation basis and also within the large discussion class. Since we have found that role modeling is an essential teaching method, the faculty acted as a panel and presented, discussed, and analyzed a case in front of the class during the fifth class period before the students began their small group work the next week.

The small groups were given cases reflecting practice situations and illustrating the ethical issues of autonomy, informed consent, allocation of resources, and accountability. We recognize that moral reasoning (reasoned decision making) is essential to our teaching efforts and therefore provided guidelines for analyzing the case studies based on Rebecca Bergman's decision-making model and further developed by us. These guidelines, which appear in full in our text [2], consider the following areas of analysis. First the learners are asked to review the case; determine who the players are and what decisions need to be made; determine what ethical issues are involved and the historical, philosophical, and religious bases for each; determine who should make the decisions (who owns it?); examine what the ICN and ANA codes for nurses might say regarding the actions needed of nurses; decide on a plan of action with reasons for the decisions; determine alternative plans/decisions that could be made and their potential implications for all concerned; and share ideas on action with all group members [11, 15, 2 pp 11-12].

Another example of a formal course in ethics involves joint medical-nursing student education at the University of Pennsylvania. We are proposing a course which will begin with formal presentations on ethics, theories, professional roles, rights and responsibilities, reasoned decision making, and collaborative efforts in health/illness care. This formal content will then be followed with biweekly grand rounds with students and faculty exploring a different case study each time. We propose to expand the decision-making team to include other health professionals and family members, as indicated, and to offer students time to explore *how* they make decisions in care and, more importantly, *why* they choose a particular decision in the given situation.

Our teaching efforts with short-term groups have varied in time from 1 hour to 8. We use seminar format, lecture/discussion, workshops, rounds, and lately involvement in medical student's Journal Club as the methods of instruction. The content outline remains the same, but the depth of presentation and time for small group work varies with the overall time assigned for the presentation.

2.3 The Faculty

The success of our teaching efforts in ethics is directly related to the nature and background of the two of us. H. Thompson provides the needed expertise in philosophy, history, religion, and ethics, while J. Thompson provides the needed expertise in nursing and practice issues. Though each of us could teach alone after 7 years of joint teaching, we think the students receive much more than two when we work together. As mentioned earlier, role modeling is very important in this difficult, yet callenging and necessary, field of study. We model for our students role definition and collaboration and put into practice the collaborative sharing of ideas and decisions (even when we don't always agree). This team effort was enhanced even more when we added a lawyer and biomedical engineer to our teaching efforts in ethics. The faculty concluded that they learned as much as (and possibly more than) the students in this class. The students supported the value of faculty willingness to openly present their individual ideas and value positions while also working towards understanding those who differed in views and orientation on crucial ethical issues.

3 Summary

In summary, we are pleased with the response of nurses and other health professionals to the learning of ethics in their practice arena. We think much of the success of our particular efforts is related to the small group discussions and application of decision making to actual practice situations. We try to present everyday nursing dilemmas for study rather than focus on the widely publicized cases such as Quinlan or the starvation of neonates. Students learn to trust and accept each other as colleagues while sharing their own beliefs/values on particular topics. They learn to work together to resolve ethical dilemmas or to be comfortable while retaining their separate positions. This of course can be done in a classroom more easily than in a work setting. But it is important to have students and nurses realize that decisions may not always reflect their own personal judgment of what should be done in a given situation. They, and we, need to understand the traditions of others as well as our own.

We enjoy our teaching efforts and encourage others to continue their efforts or to begin new ones in the field of ethics in nursing. It is challenging, interesting, and sometimes difficult to teach in this field, but it is very necessary and important for the future of our practice and the health and welfare of our patients.

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The Work Environment as a Factor in Continous Ethical Training

C. Sùs

1 Introduction

After some decades during which diverse extra-university influences have provoked the elimination of ethics from the study programs of the college of medicine and the school of nursing, we find ourselves, almost everywhere, in the explosion of medical ethics. Never, as far as I know, has so much been written, taught, or discussed as at present about the demands of ethics and deontology in the leading countries in medical science. A certain idea is extending itself and taking hold: those professions related to health have by their very nature a moral obligation. For this reason it is indispensable that the doctor as well as the nurse should know how to rationally support the ethical dimension of their decisions. And this occurs to the extent that, for example, Herranz [1] has been able to affirm: "To speak of ethics in medicine is a redundancy, since any Medical practice or clinic, which is not ethical, would be neither a clinic nor a medical practice." The ethical dimension of our occupation coincides with the spirit of the Universities, the scientific societies, or the professional organizations, and it is nowadays a topic of common interest, which is made evident each day through the newspapers and television and which demands logical and reasoned answers to the problems that are raised relating to health. Because of this, it is not surprising that, as Herranz [1] has also said, "Medical ethics is one of the few and fortunate disciplines that can, in the United States during a time of economic recession, not only maintain itself but even expand its research programs." And such is, of course, the case of my university.

The University of Navarra was founded in 1952, and began its programs in medicine and nursing a few years later, and complementing them some time later with a University Clinic that annually attends to 65 800 outpatients and 12 000 inpatients; it has 500 beds and employs 1000 professionals and staff. The preoccupation for ethics in the clinic, as well as in the college of medicine and the school of nursing, is a natural consequence of the principles that govern all our university work. In each of us, the words pronounced a long time ago concerning this by the founder of the university, Monsignor Escrivá de Balaguer [2], are ever present:

> The traits that characterize this university can be summed up as follows: education with personal freedom and also personal responsibility. As with freedom and responsibility one works at will, yielding the maximum where there is no need for control or vigilance, because since everyone feels at home all that is needed is a mere timetable. Later, the spirit of living together is generated, without discrimination of any type. It is in living together that a person is formed: where each one learns that in order to be able to demand that others respect your freedom, one must know how to respect the freedom of others. Finally, there is the spirit of human fraternity: the individual talent of each one must be put to the service of the rest; if not, their service is limited.

For us, it is an indisputable principle that the object of nursing is the care of human beings: we believe that this fact can never be forgotten or else nursing would lose its fundamental characteristics. This should not be forgotten, not even when the nurse perceives that the patient views her only as a "maintenance technician" of the complex machinery which is the human organism and does not expect or demand more from her. The nurse should never make a game out of this attitude and regard the patient as just a simple damaged biological mechanism. Why not? Purely and simply because it is not so. Man is someone so valuable that it proves entirely incompatible with his dignity to forget this while attending to him. Naturally this assertion involves a determined anthropological conception, to the effect that a human being is a creature of God with a trascendent destiny; because if, on the contrary, I believed that man were only an immanent biological machine, I would lack the moral strength to affirm the doctrine that I have indeed pointed out. I think, that any materialist could argue that this conception of man is not universally shared. This may be so. But man is "what he is," and not "what each one thinks he is"; and if one succeeds in getting to know him, the objective demands deduced from the concept will contribute, if they are respected, to the perfection of man himself. If, on the contrary, anyone does succeed in this antropologic experiment, we will inevitably destroy man, no matter how good our intentions are.

This callenge of nature to thinking man is of fundamental importance. In matters of such depth it would be gravely irresponsible to adopt positions that reverberated unfavorably in the treatment of the patients invoking as an alibi: "The matter is debatable and is being debated." To the question: "And what if man is nothing more than a piece of matter, who does not need any special consideration?" we can at least again ask "and what if he is more". The answer is simple: "If he is more and we have ignored it in practice, we have not practiced nursing, but something else which, at the most, may resemble it in some peculiar way."

2 Personnel Selection and Formation

It is not strange, considering what has been said, that we have carefully chosen the personnel which are to work in the University Clinic. The fundamental criteria of this selection can be summed up as follows:

1. It is necessary to have clear the idea just recently exposed, namely; that nursing has as its object human beings, who must be treated as such, which would be practically impossible if the nursing professionals were not aware of the magnitude, transcendency, and richness of what they have at hand
2. The determination to continually improve, onself, as much in one's technical aptitudes as in one's attitudes towards colleagues and - most of all - towards the patients
3. The temperamental characteristics necessary for the practice of this profession, among which we could emphasize: comprehension, strength, sensitivity towards personal and social problems of others, and a sense of responsibility

The selection is only the beginning of an educational process that lasts all of the professional life. It is useful to emphasize that this educational process has two dimensions that require very different treatments: technical training and the already mentioned improvement of attitudes. Anyone who shows just a little interest in educational problems knows that techniques can be learned, whereas attitude improvement is fundamentally the result of an impregnation process in an environment in which such attitudes constitute the basic framework of ordinary activity. Stated in another way: we consider that it would be useless to make any attempt to school nurses in respect to their attitudes if the preoccupation of the clinical institution were not very intense in making real, through our daily work, the type of interpersonal relations that are considered ideal.

I am quite aware that such a way of thinking implies costly demands; but I am convinced that the clinical institutions, as well as individuals, feel the same way as Sheed who rightly said that if someone does not make a persevering effort to attain goals that at first seem unattainable - and that, surely, are for the most part - one deteriorates irremediably.

For this reason, I wanted to address the subject of the work environment as a factor in continuous ethical training. Without this environment, the education would be incomplete. On the other hand, the environment in question is the result of the determination and the attitude of everyone, and not simply a topic or a sum of topics from the curriculum.

The space limit obliges me to make reference solely to the characteristics of the environment which we in the clinic believe to be fundamental. They are the following:

1. Delicate sensitivity in the treatment of patients. The present-day despisement for the forms of treatment brings about a risk of internal insensitivity that is easily translated into forgetting that each sick person requires an extraordinarily careful individual attention. As Andre Piettre [3] said, "sooner or later, vulgar behavior makes the heart vulgar."

2. Comprehension, that is the ability to put oneself in the patient's place, to pentrate his soul, to feel with him, to encompass each and every one of his possible reactions, not to label him

3. Discretion that consists in knowing when to speak and when not to speak, knowing how to say what must be said and to omit what is prudent to be omitted. This type of discretion must always be exercised and be used in relation to everyone: the patient, his family, etc.

4. Humility when things go well and also humility when they go badly, to accept our own responsibility and our failure without blaming others, or disclaiming the blame

5. Compassion that does not consist solely of someone's capacity for tenderness, but above all someone's "feeling with," and making this compatible with the application of the appropriate professional cures

6. Personalization in the treatment of the patient. In the University Clinic no one is merely a number. The patient is always called by his name. They are people that are happy to see how their individuality - and their intimacy - is respected even

while doing physical explorations, transferring them to the operating room or bathroom, etc., not only because they are wearing clothes which do not hinder the perfect realization of the techniques, but also because they are always accompanied by a nurse.

7. Care of details. All of us who work in the clinic have a reason to be proud of the impact that the care of details produces in the visitors: the cleanliness, the work environment, the friendliness, the seriousness, etc. And I want to point out here how tremendously and positively the external aspect of the professionals who work in the clinic calls the attention: I can assure you from my experience that the fact that everyone wears the uniform of their respective profession helps everyone in adopting internally the sum of attitudes that are so positive in the treatment of patients.
8. Individualized attention to the professionals. Since, as I have said at the beginning, the improvement of attitudes of professionals is an individual and permanent process, the clinic also pays individual and permanent attention to each one of its nurses.

In a first phase, when someone is incorporated into the clinic, in order to help him or her integrate as soon as possible into the group, among other things it is required that the institution's objectives be clarified, that different paths be opened to them according to each one's peculiar way of being, that they be stimulated and that their initiative be awoken so that they do not act as well-programmed robots that obey orders and nothing else, but that they be oriented toward the execution of adopted decisions, etc.

After this initial and intensive attention there follows a stimulation towards continuous perfectioning. This goes far beyond the actualization in the knowledge of techniques: it insists repeatedly in the right formation of the professional conscience based on respect for the person, on the obligation to execute intelligently and loyally the orders of the doctor, on the obligation to renounce acting according to nonethical procedures, on the necessity of extending to the utmost good education and attention to details, on the necessity to recognize that in every organization a leader is necessary to direct, on the essentialness of discipline based on justice and impartiality, and - at last - on the importance of a climate of confidence for the efficient practice of teamwork and for an improvement in the attention to the patients.

3 Organization of the Nursing Headquarters

To achieve the environment which I have just described, the nursing headquarters has adopted an organization of which we could emphasize the following:

1. It is formed by the head nurse and three general supervisors, two in the hospitalization area and one in the polyclinic area.
2. It has the efficient help of the supervisors and instructors of the various services and nursing units, to whom they delegate the organization of work of the gradu-

ates, the experience of the students, the organization of shifts, everything relative to holidays and leaves, etc. The nurses headquarters receives weekly information about all of this and in the respective reunions with all supervisors and instructors, instructs them on the directives and objectives which they must transmit to all of the personnel.

3. The nursing department, which is directed by the nursing headquarters, has been assigned all of the tasks relative to the care of patients. It cooperates with the administrative council of the clinic on three fundamental points:

   (a) The determination of the objectives of the center precisely with regard to the attention given to the patients
   (b) The assumption of competences such as the selection of the personnel to be dedicated to the attention and care of patients, the elaboration of its work force, the scheduling of conventions and perfection courses, the continuous evaluation of the nursing personnel, etc.
   (c) The active presence in advisory organizations of the administrative council: in effect, members of the Headquarters and, by their delegation, supervisors, form part within the University Clinic of different commissions, boards, and committees such as those of Investigation, Hygiene, Hospitals, Pharmacological Clinic, Laboratories, Charts Clinic, etc.

4. It is a constant preoccupation of the nursing headquarters that all personnel under its supervision continuously follow up their studies, show an interest in investigation, are up to date on the new discoveries in medicine that directly affect nursing, and that they put special emphasis in everything that they do, as much as it is possible, within the frame of teamwork.

5. Nursing headquarters takes care of orienting its personnel so that, according to their individual preferences and aptitudes, they specialize in the different areas of nursing from the choices that the clinic up to now permits: cardiology, orthopedic surgery, physical therapy, Laboratory, internal medicine, matron, pediatrics, psychiatry, operating room, intensive care unit.

6. During the year, the nursing headquarters programs and develops interdisciplinary courses and seminars in which Supervisors and instructors, graduates, and professors of different colleges participate: medicine, pharmacy, biology, philosophy, theology, etc. It also promotes the execution and publication of scientific works and the presentation of works and communications at national and international conventions.

7. Nursing headquarters pays special attention to its relations with the University School of Nursing, so that the practical teaching of the nurses is adjusted to an identical criteria, and in order that the knowledge acquired in the classroom is reinforced through its practical application. The reports of the supervisors and instructors and those of the heads of the different services to which the future nurses will rotate are fundamental for the University School of Nursing, at the time of the student evaluations.

4 Conclusions

Newman [4] said that the university is an "educational environment." A clinic, in order to be called a university, must also be "educational." But its possibilities with respect to this substantially depend upon the environment that the clinic is capable of producing. If it is appropriate, the real-life situations that the nurse finds daily in her work with patients will be decisive in her training and in her constant improvement. The spirit of the University of Navarra impregnates its University Clinic and emphasizes the Christian sense of life and, as I said at the beginning, its love of freedom and responsibility, and because of this emphasis, each and every one of the environmental characteristics which I have referred to here. I can assure you that this environment is a decisive factor in the continuous ethical training of our personnel as the accumulated results of over 30 years show.

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Research

Aspects of Ethics in Nursing Research

R. Bergman

1 Introduction

Ethics and research are both areas of major concern to nursing. They are the moral and knowledge threads that are interwoven into the fabric of nursing. Ethical behavior - the "right" and "wrong" of professional and personal decision making and action - is to a large extent dependent on available scientific knowledge. Research, a major tool for obtaining this knowledge, must itself be guided by ethical standards. This paper will share with you reflections on the ethics of nursing research and will relate to three subtopics:

1. research involving human subjects: declarations, codes, and laws;
2. research that does not involve human subjects; and
3. omissions in nursing research as an abrogation of ethics.

2 Research with Human Subjects: Declarations, Codes and Laws

International declarations, although not binding by law, have considerable moral force. The Geneva Convention (1864) protects the rights of prisoners and detainees. United Nations declarations, such as the *Declaration of Human Rights* (1948) and *Rights of the Child* (1950), deal with human welfare in the broadest sense. The American Hospital Association's *Patient's Bill of Rights* (1973) is concerned with a specific population. The objektive of all of these is to protect human beings from abuse or harm and to promote their maximum welfare.

Some documents relate specifically to research. Following the Nuremberg medical trials which revealed the inhuman acts committed by the Nazis in the name of science, the *Nuremberg Code* (1946) established ten principles of medical research. They are given in abbreviated form below.

1. Voluntary consent of the human subject (informed consent) is essential.
2. The experiment is designed to yield fruitful results for the good of society, not procurable by other means.
3. Human experimentation is based on results of animal experimentation.
4. The experiment avoids all unnecessary physical and mental harm.
5. There is no reason to believe that death or disability will result.
6. The degree of risk must never exceed the humanitarian importance of the problem.

7. All precautions must be taken to prevent any remote possibility of death or injury.
8. The experiment must be conducted by scientifically qualified persons.
9. The human subject can withdraw at any point.
10. The scientist will discontinue the experiment if continuation is harmful.

The *Helsinki Declaration,* adopted by the World Medical Association in 1964, distinguishes between therapeutic and nontherapeutic research. It has become the basis for national laws and professional research codes. In a case which reached the Supreme Court in Israel in January 1982 permission was refused to treat a terminal cancer patient with an untested drug. The Helsinki Declaration was the main source for the decision.

Additional sources of moral guidance for researchers are *professional codes.* The Hippocratic Oath (4th century B.C.) required "absolute respect for the sick" and "for human life."

The Florence Nightingale Pledge (1893) required that "I will abstain from whatever is deleterious and mischievous" and "will devote myself to the welfare of those committed to my care."

The International Council of Nurses (ICN) *Code for Nurses* (1973) requires that "nurses take appropriate action to safeguard the individual when his care is endangered by a co-worker or any other person." The ICN statement on nursing research (1977) states that "research should comply with accepted ethical standards."

Several nursing associations have published *specific ethical codes for nursing research.* Seven points from the United Kingdom Royal College of Nursing code in 1977 [4] relate to the personal responsibility of the nurse researcher.

1. The researcher is responsible for obtaining freely given and informed consent from each individual who is to be a subject of study or personally involved in a study. The researcher should explain as fully as possible and in terms meaningful to the subjects what the research is about, who is undertaking and financing it, and why it is being undertaken. She/he must make explicit the subject's right to refuse to participate or to withdraw at any stage of the project, and this right must be respected.

2. If the subject for any reason is unable to appreciate the implications of participation, informed consent must be obtained from relatives or legal guardian.

3. If the subject is a patient the researcher should discuss the proposed research with the patient's doctor or the appropriate medical officer.

4. If the nature of the research is such that fully informing subjects before the study would invalidate results, then whatever explanation is possible should be given to the subject. There must be provision for appropriate explanation to the subject on completion of the study.

5. Explanation to the subjects should include information as to how their names came to the knowledge of the researcher. She/he should identify herself/himself and the organization responsible for the study and leave with the subject a note giving this information together with a brief statement concerning the nature of the study.

6. Research subjects must be assured protection against physical, mental, emotional, or social injury. No harm must come to them as a result of being involved in the study insofar as the present state of knowledge allows.
7. The nature of any promise of confidentiality or restriction on the use of information must be made clear to the subjects and adhered to.

The American Nurses Association "reaffirmed the profession's obligation to support the advancement of scientific knowledge" in its document "Human Rights Guidelines for Nurses in Clinical and Other Research" (1975). It spells out the subject's right to freedom from intrinsic risk of injury, protection of privacy, and dignity. It provides protocols to assure that these rights are carried out by the investigator and the agency. Similar statements were published by the Canadian Nurses' Association (in 1972) and the New Zealand Nurses Association (in 1977).

Laws dealing with ethics of research are found in some countries. Nurse practice acts may limit nursing research and protect human subjects in broad terms - such as limiting nursing interventions and requiring appropriate levels of education for professional practice. Laws on research for citizens also bind nurses. For example, in the United States, the 1962 Kefauver-Harris amendment requires informed consent of the human subject. Since 1974 all research funded by the U.S. Department of Health and Human Welfare must be approved by an institutional review board.

3 Research Which Does Not Involve Human Subjects

There is much important research in nursing which does not directly involve human subjects. In such studies the researcher is freed from considerable limitations but still must demonstrate stringent ethical behavior in terms of validity and reliability of data, objectivity in analysis, and responsibility for dissemination of findings. These studies may examine materials, the physical environment, or records.

Example of studies with materials or the environment are: measuring the contamination of air or objects in a specific area, such as a recovery room; comparing the effectiveness of different agents to reduce malodors; measuring the strain to which equipment, such as patient supports, can be safely subjected.

Examples of research utilizing records are: examination of number and kinds of patient visits to a nursing clinic, comparison of agency policies, study of trends in registration in educational programs, studies of child development.

Studies that deal with records that may identify specific groups or individuals are audits of nursing records, evaluation of quality of care in a patient unit, review of reasons for attrition in a small agency, or a study of staff activity. Some of these studies may also utilize observation and/or interview in addition to records. In such cases, although there is no physical harm to the persons concerned, there is an element of intrusion of privacy and possible anxiety caused to the subject or agency, and therefore appropriate protection of the individual and agency must be assured.

4 Omission

The last area that I wish to discuss is that of omission - or "non-doing" - in nursing research. I would call this "passive nonethical behavior." Seven kinds of omissions are:

1. Inadequate response of researchers to suggestions from practitioners
2. Nonreferral of problems by practitioners to researchers
3. Refusal to allow access to the field
4. Unread research
5. Lack of application of reliable research findings
6. Unused nursing research skills and resources
7. "Giving up" desired research

I would like now to elaborate on these seven points

4.1 Inadequate Response of Researchers to Practitioners

The researcher may not seek out or respond to suggestions from the field. She may feel that she does not need this input, as her work will be based on previous research and theories. She may see her own experience as sufficient to know what is going on. She may consider the practitioner's perception as biased and/or limited and her own as more objective and comprehensive. In some instances, because of an extended separation from practice, the researcher may feel threatened by dialogue with a person who is exposed daily to direct nursing care.

Another reason for lack of sensitivity to the practitioner may be a gap in conceptual or terminological communication. In a study on the nutrition of geriatric patients, the charge nurse of the ward was concerned about the mechanics of patient feeding; the nurse researcher responded in terms of self-image, locus of control, and principles of energy conservation.

4.2 Lack of Referral of Problems by Practitioner

The practitioner may passively impede research by not recognizing questions arising from her work. If she is aware of the need for study, she may not be ready to pass on her ideas to the researcher because of previous rejection, shyness, or lack of self-confidence. Some practitioners may wish to pass on their ideas but not know how or to whom to bring their suggestions.

4.3 Refusal to Allow Access to the Field

Nurses in various levels of service or education may actively impede nursing research by refusing access to the field. Refusal may come from the administration level if the research is viewed as a burden on subjects or staff. There may be some insecurity or fear of what the findings will reveal. A study on nursing staff satisfaction in a large hospital was held up by the nursing office. They were aware of considerable dissatisfaction and had developed a plan to counteract it. They stated that a study on the subject would interfere with the planned program. In a nurses' activity study the staff objected to the presence of observers in the unit. They were afraid that the "outsiders" would impinge on the patient's privacy and would be stressful for the care givers. Interviews of both staff and administration in a study of the role of the unit head nurse met with some antagonism because it took time in an overloaded workday.

4.4 Unread Research

A further and very common omission is not reading research. The blame, if it can be so termed, may stem from several sources: the nursing education system that does not sufficiently develop the desire and skills needed in order to comprehend research; the nurses themselves, who are not sufficiently motivated to obtain and read the research journals; the authors who write for their research peers rather than for practitioners; the professional journals that require "sophisticated" reporting; and the universities that demand "scholarly" publications of their faculties.

4.5 Lack of Application

Even when research is read, understood, and found relevant to the individual nurse's area of work, findings are often not utilized. The introduction of change, based on research, usually requires team decisions and administrative approval. The concept of omission in utilization in this paper refers to ignoring findings or not taking steps to forward their implementation in practice by all levels concerned with practice. The many studies on reliability of methods of measuring patients' temperatures are crystal clear and have appeared in popular professional publications, yet little has been done to change entrenched routines. The opposite side of the coin is a commission: application of research without first ascertaining that the findings are reliable and valid for the specific situation.

4.6 Unused Nursing Research Skills and Resources

Another omission is nurses who have the skills and opportunity and do not participate in research. There are a multitude of identified questions for which partial answers could be found if nurses incorporated mini-research as part of their practice. We can learn much from systematic observations, questioning, recording, and analysis. Reasons for attrition from educational programs or employment can be learned by interviewing each leaver, and their supervisors, using appropriate tools. Recording by night nurses of reasons/situations which disturb patients' sleep can provide data which may lead to the introduction of measures for promoting rest; observing patient responses to these interventions could be a follow-up study. Nurses with more advanced preparation in research methodology should design and carry out more sophisticated studies. On-the-job research is dependent on the readiness of the nurse to do studies and an the administration to recognize its importance and provide logistic support.

4.7 "Giving Up" Desired Research

The final omission presented in this paper is giving up a project which the researcher believes is important. All too often doctoral or masters students put aside a research question that they really want to work on because their teachers are not interested in the subject. The growing emphasis on theory-based research has influenced students and faculty to identify a theory and then find a related question rather than look for theories that can help them understand or find answers to the questions that "turn them on." Research instruments today need to be tested for validity and reliability, and rather than develop and test a simple tool, we often find researchers duplicating studies of little interest to them or seeking a study to build around accepted instruments. This dependence on established theories and tools may curb original thinking and movement into new areas of investigation. This omission is predominantly found among those people who are best equipped to do original research and who have available research resources.

The 1977 statement on nursing research of the International Council of Nurses (ICN) states "different levels of sophisticiation should be utilized,. . .should comply with ethical standards,. . .[and] findings should be widely disseminated and their utilization and implementation encouraged when appropriate." This broad statement should encourage nurses to correct omissions if they are partner to them.

5 Conclusion

This paper briefly dealt with declarations, codes, and laws related to ethical aspects of nursing research which involves human subjects, with ethical responsibilities in research that do not present a danger to humans, and with ethical omissions in nursing research. The ICN Code for Nurses (1973) requires that we safeguard the individual from harm, develop a core of professional knowledge, implement desirable standards of nursing education, and take personal responsibility for nursing practice and continual learning. Nursing research, conducted in an ethical manner, will do much to forward these commitments.

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The Ethics in Nursing Research

L. Hockey

1 Introduction

I define nursing research as „research into those aspects of health care which are the predominant and appropriate concern and responsibility of nurses." it must be immediately obvious that this is neither an objectively derived nor a static definition.

What is considered to be the appropriate and predominant responsibility of nurses is determined by many factors; there are tremendous variations among countries, cultures, different care agencies within any one country, and different professional groups. There are also continuous and important changes over time. My definition of nursing research is intended to be responsive to such variations and changes.

In discussing the ethical issues of nursing research, it is important, therefore, to be aware of the context and the background against which the research is conducted.

An issue is a point worthy of debate because it is important and because it is viewed in different, often even in opposing, ways. An issue *raises* questions; it does not *answer* them. An ethical issue implies choices in relation to human conduct. An ethical issue or problem, according to Curtin and Flaherty [1], has three characteristics:

1. It does not fall strictly within any one or all of the sciences.
2. It is inherently perplexing and
3. the answer reached will have profound relevance for several areas of human concern.

Ethical issues of nursing research raise questions about whether this activity *should* be conducted or not. Is it right, is it good, ought we to do it, etc.? These are questions which imply a moral judgment.

I would like to deal with my topic from three perspectives:

1. The macroperspective; this implies a consideration of choices which confront government departments and regional authorities charged with the responsibility of providing health services in committing resources.
2. The macro/micro perspective; this implies a consideration of choices which the nursing profession has to make in its commitment in relation to research involvement.
3. The micro perspective: this implies a consideration of choices which an individual nurse has to make in relation to research involvement.

2 The Macro Perspective

Resource allocation on a national and regional basis is determined by political and economic considerations as well as moral ones; all of these are interrelated. If an activity is valued, money is more likely to be found for it; if an activity appeals to public opinion, money is more likely to be made available for it. At times of serious economic cuts, it may not be possible to find money for anything which is not considered *urgent*.

However, whether an activity is valued, whether it appeals to public opinion, and even whether it is considered urgent may be a moral rather than a scientific question. Therefore, resource allocation at national or regional levels may find itself in the territory of ethics.

In considering the allocation of resources for nursing research, it is imperative to identify the values of and beliefs about the nursing profession. Returning to my definition: if nurses are not recognized as having any predominant and appropriate responsibility in the health care of a nation, then allocation of resources for nursing research cannot be expected. Thus, professional responsibility and claim on research resources should go hand in hand. This brings me to the macro/micro perspective, the profession's choices in relation to research involvement.

3 The Macro/Micro Perspective

How does the nursing profession view research? In the United Kingdom the potential power of the nursing profession is enormous, especially in relation to the administration of nursing services and in its voice at government level. We also have an increasingly powerful nursing voice in higher education. It seems reasonable to assume that the increasing power of nurses has played an important part in the growth of nursing research in our country. At the same time, it seems obvious that only a relatively small part of the potential power of nurses is used to generate research activity and there are significant differences among professional groups within nursing. The differences are not merely due to different levels of scientific understanding or to external constraints over which nurses may have little or no control. Those factors *may* play a part, but it is *only* a *part*. Nursing research is viewed differently by different professional groups and by individual nurses; it is not equally valued, it does not appeal equally to the generic nursing opinion, and there are not too many nurses who see nursing research as an urgent priority.

I do not intend to imply criticism; I am stating a fact. There are many nursing administrators who give deep and serious thought to the services for which they are responsible and who are highly motivated to facilitate the delivery of the best possible care, however this may be assessed. They consider it right, morally right, to allocate their resources in terms of finance and manpower to the direct provision of care, to nursing equipment, to amenities, and to comforts for patients rather than to research, the outcome of which cannot be predicted. They make a deliberate choice, which they can defend on moral and ethical grounds.

There are nurse teachers who consider it "better" to prepare their students to be highly skilled in well-tried methods rather than allow them individual judgments on the basis of recent research. Research findings must be interpreted and used with understanding. They pose an element of uncertainty which may generate anxiety. There is not *always* a conflict, but there may be. To live with research is to live with uncertainty. Nurses must not be uncertain; they must inspire confidence in their patients which uncertainty may undermine. Tradition may be valued more highly than innovation. If the discovery which might warrant innovation is clearly scientifically credible, the issue is taken out of ethics, but there is often a measure of ambiguity within the concept of nursing science itself.

There are many clinically involved nurses who give devoted care to their patients but would rather dismiss any knowledge or awareness of nursing research. They consider it unnecessary and irrelevant. I refer to the potential users of research, not to active researchers. The time will come when they will have to be aware of new knowledge through research reports for legal reasons, but then the issue once again moves out of ethics. Ethics implies choices.

It seems, then, that on a macro/micro basis, looking at nursing research from the perspective of the nursing profession there are ethical issues in relation to research involvement, be it in the area of enabling, in the area of teaching, or in the area of utilization.

4 The Micro Perspective

What is the individual's, the individual nurse's, position in relation to research involvement? My focus here is on research activity, albeit for a limited period, for example, to undertake one project.

Ought I to do it? Is it right for me to devote time and energy to research rather than to the care of patients or to the education of students, depending on the nature of may appointment? Have I a right to do it? Have I a right not to do it?

They are questions affecting conduct and they seem to conform to the criteria of ethical questions. Can moral philosophy and ethics help to answer them? Many ethical theories have been expounded over the years. They have attempted to give us rules for our conduct when we have a choice. When and under what conditions is our behavior, our conduct, praiseworthy or blameworthy? Are we blameworthy if we do not use our nursing skills for the care of patients but, after having absorbed resources vested in our professional preparation, deviate from the conventional path into research? Are we praiseworthy for doing this because it may ultimately improve conditions for patients or nurses? Is it motives or outcomes which determine the moral worth of research activity in nursing? Is it the utility of the activity? It would be hard to defend it on the basis of the greatest good for the greatest number, but what about hedonism? Research activity brings its own credible pleasures and rewards; is it defensible on those grounds? Is it a means to a pleasurable end, that is, the extension of knowledge, or is it defensible as an end in itself because it stimulates thinking and critical enquiry irrespective of the end?

Nursing research has characteristics which make it entirely different from any other field of professional activity. In the first place, its potential usefulness is dependent on other people. The end result is taken out of the hands of the actor. So, while administrators can see the effects of their administration in terms of creating an environment which facilitates care, while the teachers can see the successes and failures in their students and can take direct action in relation to them, while clinical nurses relate directly to their patients and see the effects of their work, this is not so for researchers. They produce findings but they usually have no control over the use of these.

The other major difference between research and other types of nursing work is that research is not prescribed anywhere within nursing and there is no mandatory provision for it. There is no recognized grade of researcher within a health care system, no salary grading, no career pattern.

The only exceptions to this lack of recognition and prescription are academic departments of nursing. In universities, research is a recognized and valued part of teaching responsibility. Where clinical settings are linked with university departments, the senior university teacher is also a senior professional with clinical responsibility. There, the use of research becomes part of clinical practice; by use, I mean its discussion, not necessarily its implementation. Such arrangements are usual in medicine, but rare in nursing. They raise their own ethical problems in terms of *division* of responsibilities and priorities.

In conclusion, the ethical issue of allocation of resources to nursing research, which includes the provision of training opportunities, is relevant for a society which places responsibility for certain aspects of health care on the nursing profession.

For that profession, striving to assert itself as being able and willing to accept such responsibility, the ethical issues of research involvement must be urgent.

For the individual nurse any conflict between involvement in research and more conventional areas of nursing work may remain a moral problem until the ethos of nursing changes and the need to strengthen and, in many instances, begin to develop a scientific foundation becomes a generally recognized, praiseworthy goal.

Many other ethical issues are worthy of debate. Given more space, I would have addressed the issue of plagiarism, of informed consent, of confidentiality, and of the communication of nursing research.

The ethical issues of nursing research are not a concern for researchers only; in fact, it is the relationship between research and nursing which raises some of the issues. Therefore, their thoughtful discussion by all who claim professional status is urgent.

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Implication of Ethics and Nursing Research for Patient Advocacy

E. L. Bandman

In 1975, the Commission on Nursing Research of the American Nurses Association completed and released the first document concerned with the ethics of nursing research. This was just 1 year following the publication of the federal standards for the protection of human subjects. As a result of the federal legislation, a national system of review boards with responsibility for approving and supervising research was developed in every hospital, college, university, or community agency conducting research to protect human subjects.

The American Nurses Association document was aptly titled *Human Rights Guidelines in Clinical and Other Research* [1]. I say aptly because the conception of human rights is at the core of the American Nurses Association *Code for Nurses* [2] as well. In its very first provision, the code states the rights-based principle that

> Each client has the moral right to determine what will be done with his/her person [2, p 4].

This is a clear statement of the right to self-determination. Other rights-based ethical concepts in the code are that the client will be given all the information essential to an informed judgment;

> ...to be told of possible effects of care; and (on the basis of this information) to accept, refuse or terminate treatment [2, p 4].

This provision is acknowledgement of the client's right to respect and of the Kantian imperative:

> Act so that you treat humanity, whether in your own person or that of another, always as an end and never as a means only [3].

A further principle contained in the code related to this discussion is the concept of advocacy. The third provision of the code says that

> The nurse acts to safeguard the client and the public when health care and safety are affected by incompetent, unethical, or illegal practice of any person.... The nurse's primary commitment is to clients' care and safety. Hence, in the role of client advocate, the nurse must be alert to and take appropriate action regarding any instances of incompetent, unethical, or illegal practice(s) by any member of the health care team or the health care system itself, or any action on the part of others that is prejudicial to the patient's best interests [2, p 8].

This rights-based ethical charge to the nurse who assumes the duties of a patient advocate contains the seeds of conflict between a rights-based ethical view of research and research based on utilitarian social goals. This is but one example of the implications of different ethical orientations of research for the nurses' role as patient advocate. Some research is based on other than rights-based ethical orientations and thus creates challenges and problems for the nurse-advocate who supports a rights-based view exclusively.

Perhaps the Commission on Nursing Research realized the inherent conflicts in a rights-based orientation since the *guidelines* speak to two sets of human rights – those of the rights of qualified nurses to conduct research and to the human rights of the subjects of research [1, p 1]. The probability that at some point the rights of the nurse investigator and the rights of the patient subject will come into direct conflict are contained in the first page of the document in the statement that

> The subject needs to be assured that his rights will not be violated without his voluntary and informed consent [1, p 1].

The next statement in this paradoxical document

> ...guarantees that no risk, discomfort, invasion of privacy, or threat of personal dignity beyond that initially stated in describing the subject's role in the study will be imposed without further permission being obtained [1, pp 1-2].

In other words, the nurse will obtain permission to violate the patient's rights, privacy, or personal dignity. This is contrary to the *Code for Nurses* and the role of nurse-advocate as that of "primary commitment...to the client's care and safety" [2, p 8].

These quoted statements are the research commission's attempt to resolve the conflicts between the human rights of each individual to self-determination and the rights of nurse researchers to put their design goals first and ahead of patient's rights. The guidelines state that each nursing practitioner has the obligation to support the principle of self-determination as the individual's moral and legal right, followed by the statement that

> The responsibilities attendant to safeguarding the rights of other people must be freely accepted by nurses whether their roles by practitioners, educators, or researchers [1, p 2].

That statement of freedom contradicts the previous statement of the nurse's moral obligation. If the nurse freely chooses, then there is no obligation for nurses to support the human rights of patients if it gets in the way of research goals. The commission impaled itself on the horns of a dilemma of either supporting the rights of the investigator or the rights of human subjects in tough cases.

Thus, the concept of rights is not as simple as it may seem at first glance. The concept of rights has been variously defined as "needs, interests, powers, claims, and entitlements" [4, p 7]. The *Code for Nurses* defines it as the moral right to decide what will be done with the individual's person on the basis of freely given and fully informed consent [2, p 4]. In the American Hospital Association's *Patient's Bill of Rights,* it states that

> The patient has the right to be advised if the hospital proposes to engage in or perform human experimentation affecting his care or treatment. The patient has the right to refuse to participate in such research projects [5].

My first example of research, which illustrates the conflict of rights inherent in some research, is that of double-blind studies. Charles Fried makes the point that randomized clinical trials, of which double-blind studies are one kind, both represent

> ...the best hope of advancing medicine and so alleviating suffering, but appears to do so only by disregarding the rights of patients [6, p 143].

Moreover, Fried concludes that recognizing the patient's rights in this kind of experimentation may be too costly in terms of the social benefits of the research [6]. This view states that the social goal of the greatest happiness for the greatest number, a goal-based ethical orientation of Bentham and Mill, takes priority over the individual's right to self-determination. Mill states that all persons

> ...have a right to equality of treatment, except when some recognized social expediency requires the reverse [7, pp 77-78].

This may well have been the ethical rationalization behind the Veterans Administration clinical trials of antihypertensive drugs. Patients with hypertension were randomly assigned to receive either antihypertensive drugs or placebo in clinics in different cities. The study was double-blind because neither physician nor patient knew whether the drug was a placebo or an antihypertensive. Only after

> ...the mortality and morbidity in the control group with severe hypertension was so much higher, that the trial was discontinued and all the surviving patients in that group placed on anti-hypertensive drugs [6, p 145].

The experimentation was continued for several years for less severe cases until the same conclusion was reached. Fried states that even though the published reports of the research go into great detail about procedures, nothing was reported concerning what, if anything, was said to the subjects and the nature of the consent given [6].

This kind of randomized clinical trial has been reported extensively. Oral medication for the control of the blood sugar level in diabetics as a substitute for injections was tested in exactly the same way as the antihypertensive drugs. This research, however, resulted in the unexpected finding that not only was the drug of no benefit but that there was also a significant number of cardiovascular accidents in those on the oral medication. At that point, the code was broken and the research ended [6, pp 145-146].

Similar research was done concerning coronary bypass surgery in hospitals throughout the country. Some patients were referred to cardiologists who told them that a study was involved in which they were free to participate and to receive the best treatment for their cases. Only if subjects asked were they told that the choice of either medicine or surgery, significant to their very lives, was decided randomly.

Obviously, in the cases cited, and in other doubleblind studies reported in which nurses participate, the human rights of the subjects to self-determination based on fully informed and freely given consent were absent. It appears that outright deception of the subjects was practiced through withholding of vital information such as the fact that effective antihypertensive drugs were available to patients and that lack of treatment was either harmful or deadly. Disrespect for human rights was shown in not informing subjects that the choice of surgical or medical treatment for coronary artery disease was not according to their best interests but according to a random selection for research purposes. Again, deception was practiced violating the duty-based orientation of Kant's dictum to always tell the truth [3]. The nurse research participant in these cases who assumed the role of patient advocate based on a human rights-based orientation would be obligated to tell the patients all of the truth without omission of relevant information or the practice of deception and fraud. In these two cases, the rights-based orientation supports the role of the patient advocate as a moral agent revealing truths. It might, however, result in the refusal of some subjects to participate or the cancellation of the research. That raises moral issues in regard to goal-based ethics and the loss of social benefit to be derived from these findings. Double-blind studies of the kind described place the researcher in an adversary relation to the subject because the patient may be harmed or exploited on behalf of the research goals. It violates another of Kant's principles to

> Act only according to that maxim by which you can...will that it should become a universal law [2, p 39].

It also violates another duty-based ethical principle which Kant states as

> Act so that you treat humanity, whether in your own person or in that of another, always as an end and never as a means only [3, p 47].

Kant's duty-based principles clearly support the rule that research be conducted for the welfare of each subject and not for the ends of the researcher who uses human beings as means.

The nurse advocate is fortified in her objection to anything less than fully informed consent of the patient on the basis of both duty-based and rights-based ethics. The same principle should be applied to faculty research involving students or studies involving psychiatric patients, retarded patients, and other vulnerable groups. In these low-status groups, the research is usually presented by the investigator as one of great social benefit. For example, families of retarded children seeking admission to the Willowbrook facility for the retarded in New York were told that the research for which their consent was sought would be of great benefit to a great many other children. The result, parents were told, might be a great social good in the form of an antihepatitis vaccine, a goal-based ethical orientation. The children whose parents signed the consent form were admitted to the facility without waiting for months or years. They were given live hepatitis virus as the intended basis for developing a vaccine against the hepatitis rampant in below-standard custodial institutions. Here, human beings were clearly used for the goals of the research design. This is true in many studies on psychiatric patients where proxy consent is given by family or by the hospital administrator himself as guardian. The situation is coercive as are studies by faculty using nursing students in their own classes. The end is to test a particular strategy or to write an article or to complete a dissertation. In one example, a nursing instructor was doing marketing research (for which she was paid) for a vaginal tampon company using students in her own class. Not only were her students placed in a position where their self-esteem and security, in the form of grades or evaluations, depended on participation in the research but students were also deprived of instruction time spent on the goals of the course. Moreover, the research was trivial and really testing a marketing strategy. The practice of using fellow nursing students as subjects in student nursing research raises the whole question of reliability and validity. Nursing students especially, seem motivated to help other students by responding in as positive a manner as possible. Sometimes, this can be controlled by deceiving the students regarding the hypotheses to be tested, but should dishonest means be used to achieve honest ends and are the ends honest if questionable means are used? Again, the human rights interests of the subjects are set aside in favor of the research design and goals of the researcher. In the case of students, the negative effects may be no more than wasted time. On the other hand, it may reinforce students' doubts concerning the integrity of education and health care as moral enterprises.

The Nurse's Role as Advocate

Clearly, the nurse who participates in research and who considers herself to be a patient advocate supporting individual self-determination may be in a dilemma regarding her role in some investigations. The nurse as patient advocate who opposes double-blind studies and randomized clinical trials is not necessarily anti-intellectual and anti-research. As the antihypertensive drug, antidiabetic drug, and coronary bypass surgery studies show, patients were deceived and harmed by the trials. Deception is unnecessary. The nurse who sits on an institutional review board passing on research or one who actively participates in studies can insist on the principle of truth-telling. The investigator carefully explains to the patient how double-blind studies work, the risks of experimental drugs, the probability or percentage of possible benefits, the significance of the 50% chance of getting a placebo, and the subject's right to discontinue participation at any time. Would this mean the end of double-blind studies? Not if double-blind research is as carefully conceived as was that of the Salk polio vaccine studies. The research was nationwide, randomized, double-blind with a placebo, and involved hundreds of thousands of American children. The research protocol was fully revealed to parents before seeking consent. Parents were informed of risks and promised first call on the vaccine, if successful, and if the child was a control. The research worked out as both a great goal-based, social benefit and to the benefit of each individual subject who wouldn't get the vaccine any other way. Unlike, the research involving antihypertensive drugs and coronary artery disease treatment, no deceit or harms of subjects occurred. Both the human rights principle of self-determination and the duty-based principle of treating each person "...always as an end and never as a means only" [3, p 47] were honored. The polio vaccine research shows that scientific knowledge need not advance by fraud, deceit, force, insecurity, and financial rewards. The principle of educating clients through complete disclosure of even randomized clinical trials respects the right to self-determination, including unconditional support for client's right to refuse. Any other position is morally impermissible from a human rights orientation.

The nurse investigator as patient advocate practices candor and respect. If research is conducted for the investigator's benefit, an existential choice, these facts can be shared with the intended subject so that he or she can also freely choose to participate or not. Candor of this nature is essential to the validity of much of nursing research conducted on students by classmates or teachers or outside investigators desiring access to classes of students. The element of coercion in research may affect validity of the findings as well as the integrity of the instructional program. In most research, academic and clinical, respect for individual rights can be fully supported while experimentation and investigation for social benefit goes on.

In some studies, however, such as the use of experimental drugs on senile or psychotic patients which will not benefit them but may even be harmful, the nurse is forced to make an existential choice. The alternatives constitute the dilemma inherent in the American Nurses Association *Human Rights Guidelines* [1] between support of the human rights of the patient and the rights of the investigator to pursue the goals of the research. The nurse with one foot in the scientific community may choose to place both feet firmly on the path to scientific advancement through the route of social benefit for the greatest number, subordinating the interests of the individual to the whole. Or the nurse may choose to be on the side of the patient as an end and take appropriate action regarding what she believes to be research prejudicial to the patient's best interests. That nurse is truly a patient's advocate with all the trials, opportunities, and risks this position offers. In either case, the authentic choice, the existential orientation, reflects consideration of the arguments and reaches for a position which in many instances represents the paradigm of a genuine moral dilemma.

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Ethics and Research into Nursing Practice

R. Crow

1 Introduction

In discussion of the ethical issues which relate to nursing practice research, of central concern is the research approach used to develop and/or test our nursing therapy, namely, experimental research using patients/clients as human subjects. I am making the assumption that the major thrust in nursing practice research is to establish the scientific basis of practice through both advancing our understanding of practice and exploring the worth or "value" of the therapy we advocate, i.e., research to test the effectiveness of our nursing assessment/diagnosis and delivery of care. Given this framework, I want *first* to identify the main ethical issues underlying the use of human subjects in experimentation, then in discussion I shall attempt to establish how far codes of behavior guiding nursing research cover the issues, looking at the same time at the safeguards needed to ensure that nursing practice research is carried out with due regard to a recognized ethical code.

Main Ethical Issues

The main guidelines where human subjects form the basis of experimentation are laid down in the Declaration of Helsinki, which was drawn up by the World Medical Association in June 1964 [1]. The code of ethics concerns clinical research, where a distinction is made between research combined with professional care - namely therapeutic research - and nontherapeutic research the essential object of which is purely scientific and without therapeutic value to the person subjected to the research.

The basic principles covered (where the doctor is bound to the moral principle that he/she must remain the protector of the life and health of the patient) are:

1. A requirement to conform to the moral and scientific principles that justify medical research
2. That clinical research should be conducted only by scientifically qualified persons and under the supervision of a qualified medical man
3. That clinical research cannot legitimately be carried out unless the importance of the objective is in proportion to the inherent risk to the subject and careful consideration should be exercised where the personality of the subject is liable to be altered by drugs or the experimental procedure
4. Meaningful consent of the subject must be obtained

On the basis of these principles, an ethical code for nursing practice research (where nursing practice research is considered to be on a par with clinical research) should cover four central issues:

1. There is a need to ensure that the moral and scientific principles of research are maintained

2. There must be consideration of the balance between risk and benefit of the nursing therapy delivered to the patient/client
3. There must be meaningful consent
4. Careful consideration must be given to the safeguards required when carrying out therapeutic and nontherapeutic clinical research

The important question is: how far do the ethical codes for nursing research cover these issues?

In answer to the question, it would seem that most of the codes currently available [2, 3, 4] address themselves to the issues of the moral and scientific principles of research and meaningful consent, but when it comes to the problem of balancing risk with the benefit and in consideration of a need to distinguish between therapeutic and nontherapeutic research, they leave one with more questions than there are guidelines given.

It is thus these latter two areas I wish to pursue.

2.1 Risk Balanced Against Benefit

In discussions of the ethics in nursing research, risk is interpreted in two ways [5]:

1. In relation to the "individual" subject or patient's recognition of it in the context of informed consent (albeit with no mention of a distinction between therapeutic and nontherapeutic research)
2. As it concerns the risk of harm to the subjects where harm covers the physical risk, the potential degree of anxiety, fear, or distress which may be generated, and the possible imposition of discomfort. It is this latter definition of risk which is being referred to when balancing the benefits of therapy with its potential harmful effects.

In order that we meet our responsibility to the patients, we must not only recognize the *sources* of harm with some degree of certainty but also gauge the potential benefits, that is, have some idea of potential *therapeutic value* of whatever is under test. Yet there is not always general agreement in nursing circles about the "goals" of care - in short we do not always agree on what effects we expect from the various practices that we perform. Thus, how can we, with any degree of consensus, provide an objective assessment of the potential therapeutic value?

Indeed, drawing on research sources there is not much consolation that help is available for those who care to look. Most of the studies concerned with testing the effects of care are not invariably analyzed solely in terms of statistical significance between the different treatments. Scant attention is paid to the size of difference produced and its *clinical* significance, e.g., is it worth reducing anxiety and, if so, what size in reduction is needed before the results are effective? Also, what do we mean by effective? There remains the implicit assumption that removal of painful experiences and the increase of the positive/comforting components of health are "a good thing." My deep concern is that these assumptions desperately need to be put to the test, since we could be subjecting our patients to unnecessary research and thus be unethical.

Still on the subject of risk, even if there was a clearer and more generally agreed notion of therapeutic value, there remains the problem of the need to ensure that for every nursing practice research proposal there is an objective assessment, that is, an assessment by a nurse who has not been involved in the design and yet has the scientific knowledge and the understanding of the ethical principles involved. This demands that all Ethical Committees concerned with clinical research have at least one nurse member. No such situation occurs in the United Kingdom [6] and from reading the general literature I doubt that this is true elsewhere. What are we doing about it, and have we the nurses so prepared?

2.2 Therapeutic Versus Nontherapeutic Research

I now want to turn to the question of whether, in nursing practice research, there is need to recognize the importance of the distinction between therapeutic and non-therapeutic research [7].

In the Royal College of Nursing of the United Kingdom's guidelines on *Ethics Related to Research in Nursing,* no mention is made of the distinction; rather there is a statement which reads:

> g) i(a) the nurse as researcher has no responsibility for the service, care/treatment or advice given to patients/clients and should make this clear. Intervention should be confined to occasions when a potentially harmful situation appears imminent.

It would seem from this that in the United Kingdom, if not further afield, nursing has not recognized the potential ethical implication of introducing new "therapies" into our everyday practice. Ought we not to insist that new therapies are tried under strict scientific and ethical principles? For surely, the giving of any new untested therapy is potentially hazardous, and should always be considered in relation to its therapeutic value to the patient/client. Yet how often do we consider it necessary or appropriate to ask the patient/client whether he agrees to try the new therapy, assess the potential risk, systematically assess the effects such that we can evaluate the benefits? There is no way of knowing what the balance of answers would be throughout nursing worldwide, but there would seem to be a strong argument for saying that recognition of the role of therapeutic nursing practice research and the ethical principles entailed urgently needs to be addressed.

It may also be timely for us to consider whether we need to distinguish between clinical and non-clinical research. Clinical research is that pertaining to the patient's/client's therapy, and the subjects are patients, selected for their representativeness. Nonclinical research is that pertaining to theoretical or basic sciences, where the subjects are normal volunteers, recruited by letter, circular, notice board, or personal contacts. The reason I raise this question is because I am becoming increasingly uneasy about the rise in the number of nursing research programs where patients are used as subjects and yet there is no justification of their clinical significance for those patients' health status. The areas of particular concern are studies on "communication." At the moment it would seem that there is an assumption that because nurses are by definition involved in patient-nurse interaction, and hence communication, that this makes a study of it "clinical." I would like to challenge this view for the sake of airing the issue and suggest that studies looking at the communication process per se are *not* clinical and therefore nurse researchers should *not* select patients but recruit normal volunteer subjects. If we do not take ourselves to task, we could in the future have the ethics of our practice research questioned. The challenge is to establish what we consider nursing practice research to be and sort out what is the central purpose of nursing when developing therapy.

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Ethical Considerations for the Nurse Ethnographer Doing Field Research in Clinical Settings

C. P. Germain

Ethnography literally means "portrait of a people." Ethnographic research provides a descriptive analysis of a subculture and is the basis for theory development in such subdisciplines as cultural, social, or educational anthropology. Traditionally anthropologists have studied remote or exotic cultures but the need for ethnographic research of the many health care subcultures where nursing is practiced has been cited by a number of nurse anthropologists.

Nursing and anthropology are similar in a number of ways. They share a view of humans as holistic beings whose problems should be viewed in a systems perspective. Fieldwork and the research methods of participant observation and intensive interviewing are essential ingredients of both disciplines. Cassell (1980), an anthropologist, emphasizes that:

> Unlike other modes of investigation, fieldwork does not place human interaction outside the research paradigm: instead, the paradigm is based upon human interaction, in all its richness, variety, and contradiction. [4, p 31]

Glazer [7, p 25] suggests that ethical tensions are inherent in the effort to probe behind the scenes of social life. The ethical considerations addressed in this paper have been developed from a study of the research ethics literature and reflections on my own ethnographic research of an adult cancer ward in a community general hospital [6] and an ongoing ethnographic study of an abused women's shelter. Clearance to gain entrance to initiate both studies took considerable time and was obtained by submission of the same research proposal with necessary verbal explanation to the appropriate administrative bodies, committees, and staff of the agencies, as well as the committees of two universities charged with review of ethical components of studies involving human beings.

Whether this latter type of institutional review is appropriate for ethnographic research has been a matter of considerable debate because of its epistemological divergence with experimental research. In the United States, institutional research review committees were primarily formed for the protection of human subjects undergoing biomedical experimentation or behavioral research in which ethical dilemmas and risk/benefit ratio could be largely determined prior to initiation of the research. However, if the ethnographer enters a field situation as a true explorer, the ethical issues and how the subculture identifies and deals with them cannot be spelled out in advance. They become apparent as the researcher immerses herself in the life of the subculture during the data collection phase.

Prior to my initial ethnographic research, I received training in field research methods and idenpendently studied ethical guidelines such as the American Nurses Association's (ANA) *Human Rights Guidelines for Nurses in Clinical and Other Research* [1]. I also had a nursing awareness of potential ethical issues on a cancer unit, such as the use of life-prolonging technology or resuscitation of terminally ill cancer patients, neither of which occurred. However, many of the ethical dilemmas that did occur were not anticipated. Dealing with these dilemmas led to an investigation of the ethical guidelines of the discipline of anthropology and consideration of how these can relate to nursing.

The American Anthropological Association published a statement of ethics in 1971 [5] (1976) which is much more explicit in dealing with field research than the ANA research guidelines. Closely examined, however, conflicting positions are evident even within the statement on ethics. For example, one principle states:

> In research, an anthropologist's paramount responsibility is to those he studies. When there is a conflict of interest, these individuals must come first. The anthropologist must do everything within his power to protect their physical, social and psychological welfare and to honor their dignity and privacy. (p.183)

This principle does not give direction for the nurse ethnographer when members of the subcultural group the institution purports to serve (e.g., the patients on a cancer ward) are further victimized by more than their disease, that is, by those with greater power, status, and authority in the subculture. By becoming researcher, the nurse does not forfeit her advocacy role for the client of nursing services. This is the source of potential ethical dilemmas.

Nurses have traditionally functioned in institutions where they have limited autonomy, power, and control of the work environment. When studying a nursing subculture, however, power relationships, institutional constraints, and interactions with members of other disciplines must be examined by the researcher, insofar as they affect the life of the subculture. Reporting these phenomena may pose a risk for some subjects and a benefit for others, though both risk and benefit are almost impossible to measure.

Nurses using participant observation as research methodology in hospital situations may have greater conflict with recording and reporting about power relationships and interdisciplinary issues because their socialization as nurses may have been to the protection of the institution, the physician, and their nursing peers rather than to the advocacy role for their clients. Perhaps this explains why there is so little descriptive field research of nursing practice.

All researchers must deal with the rights of research subjects with regard to informed consent, privacy, anonymity, confidentiality, and the risk-benefit ratio. Additional ethical concerns of ethnographers include objectivity versus subjectivity with regard to selection, recording, and reporting phenomena (bias); intervention versus nonintervention in the activities of the subculture; and the scientific integrity of the report. The two categories of ethical concern - rights of the research subject and role functions of the nurse ethnographer - cannot be separated except for heuristic reasons. In practice, they are inextricably intertwined and will be discussed in that context.

2 Subject Consideration

2.1 Informed consent

In ethnographic research informed consent of the study population deals mainly with the privacy rights of individuals. While written consent is obtained for entry, the procedure for informed consent differs for ethnographic research as compared with experimental designs, which usually require a one-time, prior written consent. Ethnographic research is conducted over a long period of time, sometimes a year or longer. Various changes occur in the subculture and many persons enter and exit at different points. Thus, the study must be explained to newcomers and consent continuously negotiated. Also, while the study might have a specific focus on a primary subgroup of the total population involved in the study, such as professional nurses or patients, secondary subgroups are also considered research subjects. They have the right to be informed of the conduct of the study and to consent to participate. Yet, as Benoliel states:

> Signed consent forms are simply not a viable alternative in studying certain kinds of sociocultural situations, and rigid procedures for informed consent based on the experimental model of research do not make a good fit with the goals and methods of fieldwork. [3, p 125].

With regard to fieldwork, Cassell writes:

> While conducting fieldwork, investigators have comparatively little power over those who are studied: informants are usually free to leave the situation or to decline to enter interaction... [4, p 30]

However, there is variation according to the type of institution being studied. In health care institutions, patients are often captive and relatively powerless. They may fear retaliation of some sort if they don't agree to participate as research subjects. Staff on the lower levels of the hierarchy may feel obliged to participate as part of their role requirements. Researchers need to be sensitive to these nuances and be very clear about their informed consent procedures. Additionally, the costs of individual subject and staff time required for interviews need to be part of the risk-benefit analysis.

On the other hand, relatively powerless individuals may have a particular desire to participate in ethnographic research. They may perceive an interview with the researcher as an opportunity to express their opinions, to make a contribution, to be listened to seriously, and to be co-equal with others in the setting in the role of cultural informant.

Glazer points out that respondents have their own reasons for wanting to be interviewed and suggests that:

> The very attention and intimacy engendered by the interview encourages respondents to speak more openly than they normally would. [7, p 26]

To avoid the misuse of sensitive material contributed by individuals the researcher should repeatedly make clear that the interview is voluntary. The material should be subject to recall if the respondent has second thoughts about his/her contribution. This means that the researcher should be accessible for a period of time after an interview has been recorded or that interviews, tape-recorded with permission, or notes of interviews, can be reviewed by the contributor. Requests to withold certain pieces of information from the published report should be honored as long as validity and reliability are not jeopardized. Certain material can be handled in the report in such a way that the identity of individuals involved is protected. The ethical principle of respect for persons, as stated in the Belmont report [2], warrants that people should be treated as ends in telling their own story, not as means to the researcher's ends.

During the data collection stage, the researcher has no foreknowledge of what the final product of the research will be. Thus informed consent is never complete, in the sense that individuals who volunteer information (which the researcher validates) may not fully understand the implication of more widespread dissemination of the data provided if and when the report is published. Moreover, though much of the descriptive data are provided by members of the subculture, they may not agree with the analysis of the data and the conclusions derived. These are purely the researcher's, guided by his/her own theoretical perspectives. As Wax indicates when speaking of field-workers:

> If they are competent as researchers, then they must function not merely as observers (gatherers), but as interpreters and analysts. For knowledge is not simply to be plucked from the streets, and byways, but must laboriously be assembled, integrated, and refined [15, p 25].

The level of knowledge and experience that a researcher brings to the field is different from that of members of the subculture being studied, including members of the nursing subculture. Regan [12] states that ethicists must constantly cope with the fact that people are often totally unaware that there are ethical problems: "A lawyer or a nurse or a doctor may lack sensitivity to the base value at stake in a given issue" [12, 17]. Thus one must seriously consider what is the ethical way to communicate the research report and recommendations to members of the subculture studied when no provision can be made for the resources necessary to effect the changes in the system for a higher level of care.

2.2 *Privacy, Anonymity, and Confidentiality*

The usual precautions for the protection of subjects in the publication phase of ethnographic research are the use of pseudonyms for persons, locations, and institutions; the alteration of minor details and events to aid disguise; and a time lag in publication. Using such methods, the researcher aims to protect the identity of the participants from the broad public, but it is likely that members of the study population are able to identify themselves and each other in the report. The extent to which the descriptive raw data, or the analyst's interpretations, can be used in a harmful evaluative way by authority figures in the subculture is a concern.

The essence of ethnography is that members of the subculture give their own views of their own situations. Individual views, including motives and meanings of actions, given privately to the researcher, may vary widely. Also, during the data collection phase many doors are opened to a nurse researcher that are ordinarily not open to a member of the nursing staff. Individuals not only respond to questions but often seek out the researcher and provide what they consider to be significant material that social scientists might label "backstage" data. Processing this may pose a difficulty, since nurses traditionally have been socialized to keep certain backstage material from public dissemination. However, when such data are a significant part of the subculture being studied, they must be ethically treated as any other significant pieces of data. The principle is to use that material that provides rich, cultural description of continuing significance, as opposed to idiosyncratic occurrences. The researcher might not like to deal with potentially controversial material, but it becomes unethical not to deal with it.

Hansen states that confidentiality must be considered along with the rule governing any scientific enterprise:

> ...that is, that the scientist's analyses and conclusions must be adequately documented by reference to the concrete data on which they are based. Only in this way can conclusions presented be adequately assessed by other scholars and validated (or disconfirmed) by further research [8, p 132].

Tilden's comment is right on target. She states:

> If the investigator has been completely candid about his study, has constantly negotiated consent with his actors, and has involved them in every step of the way as participants and coinvestigators, then publication should bring few surprises to the group [13, p 78].

2.3 *Risk-Benefit Ratio*

Risk-benefit ratio considerations weigh the potential harm to individuals, the subculture, or the institution that might result due to loss of privacy, anonymity, and confidentiality against society's right to scientific knowledge.

Risks occur during the data collection phase and at the time of publication of the ethnography. Risks are minimized, however, when participation of individuals is voluntary, contributions of individuals and subgroups are carefully validated, the researcher's role is publicly known rather than concealed in any way, and efforts are painstakingly made to preserve anonymity of the subculture and its members at the time of publication of the report.

The scientific benefit is that ethnography provides descriptive theory and analysis of a subculture as well as hypotheses for more rigorous research designs. An ethnography also becomes part of the history of a subculture. Secondary benefits of the research are difficult to assess for the group being studied. However, presentation of the "reality" of a health care subculture can lead to improvement of the quality of care in similar subcultures by providing a data base for the examination of health care system needs and problems. Some benefits are believed to accrue to individuals in the subculture who have an opportunity to "tell their own story."

Additional risk-benefit considerations for subjects are integrated in other pertinent parts of this paper. It should be noted that the researcher is subject to various risks such as injury, infection, and legal involvement (field notes of anthropologists have been subpoenaed).

3 Researcher Considerations

3.1 Objectivity Versus Subjectivity

Researcher bias can arise due to prior nursing socialization as well as personal and professional experiences in similar subcultures. There is also the possibility of bias when studying the members of one's own profession. Thus, a determined effort must be made to attend to the various elements that contribute to an unbiased, holistic view of the subculture. Quint [11] emphasized the necessity of recognizing one's inner conflicts and biases and using them as an essential part of the data being collected and analyzed.

3.2 Intervention Versus Nonintervention

As a research scientist the ethnographer is trained to stand back and observe and not to intervene, though some reciprocity in the activities of the subculture is appropriate. On the other hand, not only is the nurse socialized to intervene in health care situations, she also carries a social responsibility to do so by virtue of her license to practice.

My identity in the research subcultures is primarily as a researcher who is also a nurse with an interest in the problems of the people being studied. Participation in the care of patients or clients is limited to meeting immediate needs for support, safety, comfort, or physical care when these needs are obvious or requested and a staff person is not immediately available. Reciprocity with the staff takes the form of consultation regarding client care problems, the provision of relevant articles from the literature, transportation of clients and similar minor tasks, and contributing unconfidential information regarding clients to the staff which is perceived to be necessary for their care but unlikely to be communicated to the staff, e.g., specific concerns regarding postdischarge care. Obviously a good deal of time is spent listening to patients, families, and staff. Since this provides a source of emotional release and ventilation for them not otherwise available, I do intervene. But, as Valentine states:

> Nor do we feel it is always possible to avoid intervention, especially in participant ethnography which requires that one constantly interact with the community not just as observer but also as fellow citizen [14, p 105]

Overall, my role is the low-keyed observer-as-participant, which allows movement in and out of pertinent situations smoothly. According to Junker:

> This is the role in which the observer's activities as such are made publicly known at the outset, are more or less publicly sponsored by people in the situation studied, and are intentionally not "kept under wraps." [9, p 37]

This aspect of the participant-observer continuum permits comparative detachment, objectivity, and empathy as explained by Junker [9, p 36], although in the course of the research all roles on the continuum are probably assumed at some point. However, many researchers would agree that the full participant role cannot ethically be assumed in a deliberately covert, deceptive way.

It is conceivable that nurse researchers will find themselves in fieldwork situations in which it would be ethically intolerable to stand by and observe cultural scenes, such as situations of exploitation or threat of real harm to members of the study population. Not to intervene would connote passive acceptance. In such situations, as Pelligrino states, "whether to act or not to act in order to protect the patient is the final test of one's moral integrity" [10, p 29]. The nurse researcher must weigh possible or even probable termination of the research, and thus the loss of societal as well as personal, professional gain, against the immediate risk of harm to individuals in the setting.

4 Conclusion

Ethical dilemmas for the nurse ethnographer doing fieldwork in clinical settings occur both during the data collection phase in the field and at the time of writing and disseminating the report. In the clinical setting, the ethical dilemmas faced by the nurse ethnographer are those that are faced with varying levels of awareness by nurses and other respondents in those settings. The nurse researcher must decide when to stand back and observe or listen to how the subculture identifies and deals with actual issues and if, when, and to what extent to intervene. This may prove quite discomforting because of the different levels of knowledge and ethical awareness, experiential background, and value system of the researcher compared with those of the respondents. Working through ethical dilemmas is a necessary part of the fieldwork experience and a growth experience for the investigator. Publication of the way ethical dilemmas are dealt with becomes a resource for readers of the report who can vicariously share the experience of others in learning to deal effectively with similar occurrences in their own clinical settings.

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Additional Reading

The Final Regulations Amending Basic DHHS Policy for the Protection of Human Research Subjects (1981) Federal Register 46: 8366-8392

Attitude of Nurses to Euthanasia of Terminally Ill Patients

V. B. Shachar

Nurses' attitudes to euthanasia have been examined in one general hospital in the center of Israel. Before discussing the findings of this research, I would like to discuss some ethical, legal, and nursing aspects of euthanasia.

The term euthanasia has a Greek origin: *eu,* pleasant, easy, painless; *thanatos,* death. The term refers to painless death; from a practical viewpoint, euthanasia refers to activities aiding in easy and painless death [5]. In modern society determining death and the time of death is becoming more and more controversial. Advances in medicine and technology have made possible the prolongation of the life processes in persons who would in the past have been considered dead [7]. The passing point between life and death is becoming more and more difficult to determine. Is a human being, suffering from severe head injury who is being kept alive in a vegetative state by artificial respiration and intravenous feeding with the heart still beating, alive or dead? What is the quality of life? Any activity or treatment that would prolong life under such conditions raises the question of euthanasia.

2 Types of Euthanasia

Legally we can define types of euthanasia:

1. Active euthanasia,
2. Passive euthanasia,
3. The supplying of narcotics,
4. Aiding in suicide

2.1 Active Euthanasia

An action or activity that brings about the death of a human being is active euthanasia. The law in Israel and other countries (especially the Anglo-Saxon countries) considers active euthanasia as murder and the punishment is possible life imprisonment.

Article 300 of the Israeli Criminal Law (1977) states: "He who causes with premeditation the death of another human being shall be accused of murder and sentenced to life imprisonment." I must stress that the law has no regard for motive.

2.2 Passive Euthanasia

The doctor is under no obligation to undertake unusual activities, "activities that a reasonable doctor would not perform." The doctor-patient relationship is contractual. The moment the doctor undertakes the responsibility of treatment he should act "skillfully and according to medical ethics." From this there follows that if the patient is conscious and refuses treatment, especially unusual treatment, there is no obligation on the part of the doctor to give such treatment and he is exempted from criminal responsibility [3]. Furthermore, medical ethics do not require a doctor to perform unusual or "heroic" activities.

2.3 The Use of Narcotic Drugs

The question arises, what is behind the use of a narcotic drug? Is it used only to relieve severe pain or is it given continuously, with the intention of shortening the period of suffering? This question has not been tested legally because of the difficulty of finding evidence [8].

2.4 Aiding in Suicide

Article 302 of the Israeli Criminal Act (1977) states: "Anyone who persuades, advises or aids in suicide is sentenced to 20 years of imprisonment." In Israel aiding a person who wishes to die is prohibited. In the United States a statute of the State of California (1976) allows a person to write a "living will" in which he can request the termination of any treatment that would prolong his life. A person can sign such a will 2 weeks after a diagnosis has been made and it is carried out 1 month from the day of signing. In 1977 seven more states in the U.S. passed similar statutes (Nevada, Oregon, North Carolina, New Mexico, Texas, Arkansas, and Idaho) [2].

3 The Ethical Problem

This is the problem of the value and sanctity of life. Who is to decide when life has become of no value and that death is to be preferred: the patient, the family, the doctor? Who is to decide and who is to perform euthanasia and under what conditions [4]? I shall not enter a discussion on these questions. I would only say that the medical ethical code does not require a doctor to give heroic treatment. The Hippocratic Oath states: "I will not give a fatal draught (drug) to anyone if I am asked, nor will I suggest any such thing."

Both the Christian and the Jewish religions are against euthanasia. It is forbidden to perform any activity that would bring on death in a dying person at any stage, and he who does is considered a murderer. Nevertheless, progressive streams in Judaism believe that a human being facing the termination of life should not be intercepted by artificial measures (Rabbi Eliezer Waldenberg) [6].

4 The Research

The aim of this study [1] was to examine the attitudes of nurses toward euthanasia and the factors that affect them.

1. To examine attitudes toward the terminally ill patient and his family
2. To examine nurses' attitudes toward life and the prolongation of life
3. To learn about nurses' attitudes toward death, euthanasia, and the termination of life and the factors that affect them
4. To know how nurses solve conflicts and moral dilemmas connected with euthanasia
5. To understand how nurses cope emotionally with the terminally ill patient and his family

4.1 Variables that Were Examined

1. The kind of department and the number of terminally ill patients in it. It was assumed that the type of department affects the nurse's attitude.
2. The degree of closeness and intimacy with patients, assuming that the nurse's attitude changes as she is in close relationship with the patient or with the doctor (e.g., staff nurse or head nurse)
3. Professional level. It is assumed that the more professional the nurse, the more different her attitudes towards life and death. Professional level is connected with the previous variable also. Generally, the more professional nurses have administrative roles in the hospital.
4. Personal involvement and experiencing death situations in the nurse's family. It is assumed that a nurse who had herself experienced death situations and crises could have attitudes different from those of a nurse who had no such experience.

4.2 The Testing of Variables

The variables were tested by presenting cases and events to nurses in five departments. The nurses were requested to express their attitudes to the given events. The events represented ethical and moral dilemmas to life, death, and euthanasia.

Several evants were represented:

1. The doctor has a positive attitude and the nurse is against.
2. The doctor is against euthanasias while the nurse has a positive attitude toward it.
3. An event representing the relation to the terminally-ill patient's family and the degree of considering their opinion.
4. An event representing a grave conflict between doctor's and nurse's attitude and the ways the nurse resolves these conflicts.

The sample population consisted or 44 nurses from one general hospital who were interviewed in five departments that were chosen according to the hypotheses. The departments were: pediatrics, medicine, surgery, intensive care, and oncology. Departments with small numbers off terminally-ill patients were compared with departments in which most of the patients are terminally ill or are suffering from life-threatening conditions. In each department all the nurses on different duty shifts were interviewed. The sample included 21 registered nurses. 15 practical nurses and 8 student nurses [1]. Of the 36 graduate nurses interviewed, 11 were headnurses or assistants and 25 were staff nurses.

Some demographical findings were shown in Table 1.

Table 1. Demographic findings

Marital status		Age of nurses	
68%	Married	50%	Below 20
32%	Single	35%	20 to 30
		15%	50 to 60

Birthplace			Professionel level		
%	N		%	N	Level
43.2	19	Israel	47.7	21	R.N.
38.6	17	at least 10 years in Israel	34.1	15	P.N.
18.2	8	(Russian) 2-5 years in Israel	18.2	8	Students
100			100	44	

Role in the department		
%	N	
25.0	19	Head or assistant
56.8	25	Staff nurse
18.2	8	Students
100	44	

4.3 Results

4.3.1 Attitude toward Euthanasia

It is interesting to note that 43% of the nurses (19) had positive attitudes toward active euthanasia (Table 2).

Nurses attitudes to massive use of narcotics even if it will hasten death: 45% (24) had positve attitudes towards giving a lethal dose of a narcotic: out of these 38.6% would inject it themselves and 18.9% would ask the doctor to do it.

Table 2. Positive or negative attitude toward Euthanasia

%	N	
20.5	13	Positive attitude for maintenance of life only
27.3	12	Positive attitude to passive euthanasia
43.3	19	Positive attitude to active Euthanasia

Table 3. Nurses attitudes to massive use of narcotics even if it will hasten death

%	N	
44.5	24	Positive attitude toward giving a lethal dose
38.6	Would inject it themselves	
18.9	would ask the doctor	
27.3	12	Positive attitude toward giving narcotics to ease pain
18.2	8	Negative attitude toward giving narcotic at all
100	44	

The nurses were asked what their attitude is towards *Active-Voluntary Euthanasia* and if a patient would sign a "living will" and the time would come to carry it out, what would they do? 41% (18) answered they would respect the will and would carry it out.

(Nurses were asked what their attitude toward Active Voluntary Euthanasia is and if a patient would sign a "living will" and the time came to carry it out, what would they do?)

Table 4. Nurses attitude to Voluntary Euthanasia (active)

%	N	
40.9	18	Respecting the contract and would carry it out
18.1	8	Indentifying with the contract but would refuse to carry it out
20.5	9	Would not identify with the contract but would fulfill doctor's order
20.5	9	Would not identify and would not carry it out
100	44	

How does the nurse solve conflicts and ethical dilemmas? A case was presented in which the nurse's attitude is in favor of prolonging life, while the doctor has decided that there is nothing to be done and to give the patient suffering from metastatic cancer a narcotic drug intravenously.

Nurses' responses to such a dilemma were: 61% (27) would not fulfill doctor's order when it is against their conscience; of this number 36.3% (16) would refuse absolutely while 25% (11) would manipulate the orders like asking another doctor in order to get a different directive.

Table 5. Nurses' responses to dilemmas (conflicting situations)

%	N	
61.6	27	Nurses would not fullfil doctor's order
36.3	16	Would refuse absolutely
25.2	11	Would manipulate the situation (asking another doctor)
20.3	9	Would fulfill the orders because "we cannot disobey"
18.2	8	Would try to change the orders.
100	44	

It is interesting to note the difference in behaviour found between nurses born in Israel and those who were new immigrants. Those from Russia conceived the doctor's instructions as "something sacred" while the Israeli nurses, especially those registered, perceived their role as professional with independence.

Table 6. Nurses attitudes towards involving the family of the terminally-ill patient with the doctor's decisions. 47% (21) thought that there was no need to involve the family, only the doctor should decide

%	N	
47.7	21	Not involve family (doctors decision only)
22.8	10	Doctor's decision and family
29.5	13	Involve those families that are for life maintenance
100	44	

Table 7. Nurses attitude toward personal initiative aiding in Euthanasia. This was studied by presenting a case in which the nurse caused some damage to a breathing machine. 65% (29) had a negative attitudes to the personal initiative of a nurse. Nurses attitudes towards involving the family of the terminally-ill patient with the doctor's decisions. (By representing a case of a baby connected to a breathmachine)

%	N	
65.9	29	Negative attitude to personal initiative
20.5	9	Identify with the attitude but not agree
13.6	6	Understanding the approach but not agree.
100	44	

Findings: With Significant Correlations

Examining the relations between variables proved some of the initial assumptions:

1. A correlation was found between the kind of department and the attitudes of Euthanasia. In a department with a large number of terminally-ill patients, the nurses' attitudes to Euthanasia, even active Euthanasia, are positive.
2. In all departments except Pediatrics, nurses refuse to carry out instructions which go contrary to their conscience and beliefs. In the Pediatric Department we studied, the staff was comprised mainly of practical nurses and nurses-maids; this could explain the differences in the tendency to carry out doctor's instructions in such situations.
3. Correlation between department and family involvement.

In the Department of Oncology and Intensive Care there is a tendency to involve the family because of long hospitalization and intimate relationships with families. In the Pediatric Department they were all against involving the family. One of the reasons for this could be that it is hard for the family to decide on Euthanasia for their child.

Conclusions

1. A correlation was found between the kind of department, the place in which the nurse works, the team with whom she is working and her attitudes. The nurse identifies with the values of the team she is working with.
2. Nurses tend today to act in a professional way with accountability, i. e. to receive instructions, to judge them and to take responsibility and not just to carry out the instructions.
3. A lack of knowledge in legal, moral and ethical aspects of nursing.
4. Hospital staff tends not to involve the patient and his family in decisions connected with treatment.
5. There is a need in nurses for self-expression - for sharing of emotions and feelings and for advice while treating the terminally-ill patient and his family.
6. The study was carried out with a small sample and in one hospital, and it might be interesting to do a study on a larger scale.
7. There is a need for more involvement of patients in their treatment and to receive their informed consent.

In summary. It is known that Euthanasia is actually taking place in hospitals but nobody talks about it. It is done involuntarily without consulting the patient or his family. There is a need for legislation on Voluntary Euthanasia and "Living Will" and to assign a committee in every hospital that would decide on the continuity of treatment or its cessation.

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Decision Making

A Framework for Resolving Ethical Dilemmas in Nursing Education

J. Rosenkoetter and M. Rosenkoetter

In the last few decades, the complexities of living have multiplied geometrically and so have the ethical dilemmas that confront us all. Understandably, then, there has been a burgeoning interest in ethics and moral philosophy. In nursing, there has been a parallel increase of attention directed toward ethical issues in nursing practice and toward the teaching of ethics in nursing programs. As Davis and Aroskar state, "The nurse is concerned with values, choices, and priorities related to the 'good' of the individual, the profession, and society "[8, p 19]. It seems consistent then that the scope of this concern must be broad enough to include nursing education. However, little appears in the literature relating to an ethical base for this area of endeavor.

While faculty and students alike need to address themselves to ethical issues involving patient care, they must also address those issues inherent in the education process, whether they arise in the clinical setting, the nonclinical instructional setting, or within the larger educational milieu. They furthermore must address those issues in a reflective, informed, and rational manner. Thus, the need arises for an ethical framework, germaine to the educational setting, which facilitates the resolution of ethical dilemmas.

Fromer [11] describes an ethical base as

> ...a system of moral principles, rules of conduct about a particular class of human actions or a particular group of people. Ethics is also that branch of philosophy dealing with values relating to human conduct in respect to whether certain actions are right or wrong and whether the motive and ends of such actions are good or bad.

By virtue of involving goodness, or the rightness or wrongness of a situation, ethics includes a study of values - those concepts, beliefs, and attitudes which are sanctioned by a person or group of persons within the context of society. Evolving over time, ethics become standards for behavior [10, p 9] which reflect one's beliefs. These standards convey the moral essence of a person and collectively are demonstrative of the ethical codes of a profession.

Ethical beliefs precipitate feelings but must be processed by the mind. Simply to feel that an act is right or wrong without fully comprehending its significance or its consequences is to deny oneself the freedom of formal reasoning, a process reserved by evolution for human beings alone. In utilizing moral principles as integral parts of an ethical belief structure, humanity is indeed separated from infrahuman beings. Charles Sumner stated that "the true grandeur of humanity is in moral elevation, sustained, enlightened and decorated by the intellect of man" [9, p 407].

Sigman has indicated that "Responsible ethical choice. . .involves responsibility, accountability, risk, commitment and justice" [15, p 40]. When making ethical decisions, a person needs to be not only responsible and accountable but also aware of the risks involved and committed to both the process and the outcomes. Justice, in the sense of fairness, is an underlying concept. Sigman continues that an ethical action must be ". . .intelligent, reflective . . ., free . . ., responsible, and consistent with values . . ." [15, p 41]. Justice, however, does not presuppose freedom. A person can provide for unmitigated fairness and concern for the interest of others without permitting them freedom [13, p 103] or freedom of choice. Commitment is also necessary, but it must be genuine, not merely blind devotion to a system formalized by others [2, p 299].

Callahan and Bok [5] propose that an ethic becomes

> . . .a type of corrective vision. [It] . . .relies heavily on the distinction between the descriptive and the prescriptive, between what is and what ought to be. It throws the accepted world into a new light, an unexpected horizon; it opens up new possibilities for action, so that behavior that a moment ago seemed so plausible and imperative now loosens its hold and its power to compel (p 240).

Through ethical reflection, other alternatives, other choices, once discarded now seem more relevant.

Nursing education, by its very essence, is concerned with the development of undeveloped potentials. In being such, it is characteristically teleological - directed by an image of its product, namely, the learned student [3, p 33]. Some time ago, John Dewey [1, p 120] suggested that it is essential for the student in this quest, to be able to relate the intellectual and the moral. The student needs to understand the moral and ethical aspects of intellectual choices and conflicting or potentially conflicting realities. Moreover, it is paramount that the student have situations to which values are relevant and concepts can be applied. According to Dewey, "The attempt to attach genuine moral considerations to the mere process of learning and habits which go along with learning, can result only in moral training which is infected with formality, arbitrariness, and an undue emphasis upon failure to conform" (p 121). It is the responsibility of faculty to provide situations that promote the ethical enhancement of students.

Since Curtain [7, p 5] and others have stressed that nursing is indeed a moral art, an understanding of the ethicomoral aspects of nursing practice and nursing education becomes essential. To gain this, both faculty and students need to have the opportunity to develop and utilize skills in ethical decision making. If the two are to realize ethical growth, decision making must be a consciously rational and reflective process. For as Sartre has said, "Man is nothing else but what he makes of himself" [6, p 83].

Faculty can no longer simply be teachers, guarding their skills and possessions of the past [2, p 287], protecting their knowledge and imparting it sparingly and appropriately. Nor can they be what Barnes called ". . .pragmatic realists. Secretly content with things the way they are. . .".

In Buber's view, the effective instructor develops self-awareness in order to educate effectively. As a result, the educator learns that there is a major point of access to the student, namely, the student's confidence [4, p 106]. Without confidence predicated on trust, an instructor has little hope of assisting the student learn to choose between right and wrong, between what ought to be and what should not be. Belief in the student is utmost in this process; reciprocally, the student must be able to believe in the instructor. The words of Kahlil Gibran [16], "I believe in you and I believe in your destiny," (p 38) seem an effective beginning for student-faculty interactions.

Morris states that "If education is to be truly human, [however,] it must somehow awaken awareness in the learner - existential awareness of oneself as a single subjectivity present in the world" [12, p 110]. This awareness as a nurse begins with the faculty. Faculty must be aware of themselves as human beings, their values, the choices they are making, and the consequences of those choices. In being both responsible and accountable, they must be aware of existing standards and codes of acceptable behavior. They need to constantly be aware of the rights of not only the patient but also of the student and even of other faculty members. Their decisions must be clearly focused within the framework of societal expectations and fully acknowledge the limitations of any situation. Self-awareness further helps both the student and the faculty to control bias [14, p 706], by helping each to view the basis of choices in perspective.

To achieve all of this, it is essential that faculty take part in the lives of their students [4, p 106], helping them to deal with their thoughts, their values, their choices, and the consequences of those choices. Students need to be able to respect and trust faculty, and the faculty need to be able to respect and trust students before attempting to deal with their choices. This implies knowing and reciprocity. Faculty need not try to impose their values and ideas on students, but they can state them. It is important for students to know how the faculty feel, what they have chosen, and what they believe. But imposing one's beliefs on another is to deny that person freedom of choice and the right to be right or wrong.

Students have the right to be wrong, but not at the expense of the patient. Faculty therefore assume a variety of roles, including that of facilitator and decision maker, not in an attempt to impose their beliefs on the student, but in order to intercede according to the best interests of the patients. Students can learn from this process. They learn about ethical decisions and about conflict as an elemental ingredient of the decision-making process. They can learn that often there are a variety of alternatives and that there may be more than one appropriate choice.

Each person has the freedom to choose, but must exercise it responsibly, and be accountable for those choices. Simply making a choice does not imply responsibility or even accountability. Responsible choices involve awareness - an awareness of the consequences. One can not become fully accountable for what one does not feel fully responsible. Ethical choices and decisions need to encompass responsible choices. Each person needs to be aware and be able to deal with the consequences of the choices which are made and the consequences of those choices for *others* involved. Failure to do so is also to deny oneself the freedom to choose responsibly between rightness and wrongness, between what is valued and what is not valued, and to be fully accountable for one's decisions.

Freedom also has limitations and one must be aware of "...one's own freedom in the act of choosing" [12, p 47]. Choices or decisions need to be based on a rationale and a process of formal reasoning. But faculty need to make a logical appraisal

[3, p 43] of situations prior to making a decision. Choosing also precedes this reasoning, since one can choose whether or not to reason.

In their interactions with students, patients, and with one another, faculty need to demonstrate consistency - consistency both in beliefs and between actions and beliefs. Their choices and their behaviors need to be reasonably predictable, reliable, and authentic if they are to be role models and effective educators. Values and decisions need to be integrated into a meaningful, harmonious relationship to ensure that consistency. Although no two situations are entirely alike and ethical situations are characterized more by ambiguity than clarity, consistency between actions and beliefs is still possible. Faculty do not always agree; in fact at times it seems they rarely do, and faculty can not respond exactly the same in all situations, but each person can make similar choices in similar situations.

It is customary, for example, for students to learn communication techniques and to utilize these in their interactions with patients, faculty, and with one another. When they do not do so effectively, faculty indicate that their performance is less than satisfactory. If students were, however, to observe faculty in faculty meetings, or in one-to-one interactions, frequently it would be the faculty who would receive the unsatisfactory mark. Under these circumstances, faculty have demonstrated inconsistency and that they have chosen to value one set of standards for students and another for themselves.

Perhaps the most basic and relevant assertion is that faculty must be competent, not only as educators but as practitioners. In order to fully understand the various alternatives and consequences and in order to assist students to do the same, faculty need a substantive nursing knowledge base. If students are to view faculty as role models and learn from the ethical decisions which faculty make, then such competence is requisite.

Through mutual reciprocity, students and faculty can develop an interdependent role-modeling process through which each learns from the other. When faculty and students become able to share their beliefs, their values, their knowledge, and when they are able to discuss the choices, the potential consequences of choices, and their responsibilities, each has the opportunity to learn from the other. Each person brings uniqueness to the situation and provides the other with a personal, experiential resource and a knowledge base which can be the basis for decision making and mutual ethical enhancement.

The following situations are examples of ethical dilemmas involved in the teaching of nursing. Each involves questions of responsible choice and focuses on the patient, the student, or the faculty member as the principle decision maker. Each also has consequences for a variety of other people, who may also need to make choices. The following three relate to the clinical teaching of nursing.

Situation 1. Mrs. Clearwater, a 19-year-old American Indian, is being admitted to labor and delivery for the birth of their first child. Although prenatal care was available in a nearby free clinic, the Clearwaters preferred to follow their own customs and rituals in preparing for the baby.

Mr. Walker, a 21-year-old male nursing student, is assigned to Mrs. Clearwater. He is an above-average student but has had some difficulty with his role in labor and delivery. Although Mr. Walker has been scheduled in labor and delivery for the past 2 weeks, because of a low census, he has not be able to care for a patient in labor. This is the last day of his rotation. A nursing history and nursing care plan for a patient in labor are necessary for satisfactory completion of the course requirements.

While Mr. Walker is admitting the patient, the assigned physician approaches the clinical instructor and states, "Mr. Clearwater does not want a male nurse taking care of his wife. The patient prefers to have her mother present." The physician simply states that he agrees with the patient and her husband and that he wants the student removed from the patient's room.

Situation 2. Mr. Roberts, a 57-year-old male, had a hernia repair early in the morning. Although his history indicated that he was in excellent health, he developed intermittent premature ventricular contractions during the surgical procedure. Following medication, these subsided. He was taken to the recovery room in satisfactory condition and later transferred to his room.

Mrs. Wilson, a second-year associate degree nursing student, was assigned to him. The student received report from the recovery room nurse and the team leader. Routine postoperative orders were written. The patient was attached to a cardiac monitor as a precautionary measure for observation. The student was instructed to take the patient's vital signs every 15 min and report any major changes in the monitor reading.

An hour later, the team leader checked on the patient. He was in acute cardiac distress and the monitor was disconnected. The student said, "He took off the electrodes. He said he refused to be connected to one of those machines. I explained the importance of the monitor, but he told me to leave the room. He looked alright and really insisted, so I left him alone." The patient was transferred to intensive care in critical condition. The student approached the faculty member and asked how this would affect her standing in the program.

Situation 3. Miss Barnes is an 18-year-old, unwed mother of two children and is 2 months pregnant. She and her children are regularly seen in the clinics of the local health department. Both children are current in their immunizations and appear well nourished and in excellent overall health.

Mrs. Fletcher, a 35-year-old graduate nursing student, is assigned to the client as a part of her community nursing experience in her major. The student and client have established an exellent rapport during the two visits Miss Barnes and her children have made to the clinic. During the third visit, Miss Barnes indicates she is considering having an abortion.

After this visit, the student seeks out her clinical instructor and says that since she (the student) is Catholic, she can no longer continue to work with this client. Doing so would be in violation of her religious principles and what she believes are the rights of the fetus. The student asks to be able to select another client so there would be no conflict with her personal and religious values.

In nonclinical instructional settings, faculty and students face dilemmas of equal concern. The following two situations are illustrative.

Situation 1. Two masters' prepared faculty are teaching different sections of a course on nursing thories. They have similar backgrounds and both have taught the course several times before, but not at the same time. Although the course descriptions and objectives are the same for both sections, assignments are quite different.

In the one section, there is a mid-term and final examination as well as a research paper and critique of a major text. In the other section, there is one classroom presentation and a short paper. The students have complained to the director of graduate nursing studies and the dean of nursing about the disparities in the requirements. The faculty feel they have the right and the academic freedom to determine the course content and requirements for their own sections, just as if they were separate courses. While the director of graduate studies concurs, the dean feels that the sections should be as similar as possible in order to preserve the rights of the students, prepare them for comprehensive examinations, and protect the institution against liability.

Situation 2. Dr. Larson is an associate professor in nursing with a considerable number of years in both practice and teaching. He joined the university 3 years ago and is now eligible for promotion to full professor. In both the clinical setting and classroom he is widely respected for his expertise and relates extremely well with students. His evaluations by students and the dean have been outstanding.

Dr. Larson is also involved in research and extremely active in political affairs affecting nursing and the community as a whole. After much research and dialogue, he has recently taken the stand that it is mandatory that taxes be cut drastically in order to halt the upward spiral of inflation. This will, however, also mean that the university will loose a considerable amount of its funding and may even necessitate the loss of several faculty positions.

His political activities have been sharply criticized by the community, by the administration of the institution, and by the faculty. He has been warned that this may unduly affect his ability to be tenured and promoted.

Feeling the intensity of the controversy and wanting to protect his position, he takes the issue to his students, requesting their endorsement and active support against the university and the tenure committee of the school of nursing.

In each of these situations, what choices are available and what are the underlying values inherent in each? What are the consequences of the choices, and what risks are involved? What is the ethical responsibility of each person, and who is accountable for what? Can there be justice? Does each person involved have the freedom to make a choice or are values being imposed? How would consistency be addressed? Are the rights of the persons protected? What choices are responsible?

Although there are a variety of alternatives in these situations, there are no arbitrary solutions to the dilemmas. Faculty need to determine the nature of each dilemma and to be aware of the choices which are available. They need to assess the consequences of each alternative as well as the underlying values. To do so responsibly, each needs to be conversant with acceptable standards and the rights of persons involved. Limitations must be recognized. Risks should be identified and an attempt should be made to make a choice based on fairness to the individuals involved. This assumes competence and requires consistency in decision making. Students, whenever appropriate, need to be involved in this process so that each can learn from the others while maintaining each person's freedom of responsible choice. Reflective reasoning is the foundation for this process and incorporates the mutual trust and confidence of each person involved.

A variety of other dilemmas in the educational setting could be posed. For example, is it ethical to utilize behavioral objectives? Is it ethical to evaluate a student's attitudes as a part of the affective domain? What is the ethical responsibility of faculty regarding the amount of "practice" that students can do on a patient? What is the ethical responsibility of faculty regarding their credentials for courses that they teach? Do faculty have an ethical responsibility to prepare graduates for the roles they will assume upon graduation or for the ones which the faculty feel are appropriate? Is ethical to admit students to nursing programs when the future of those programs is uncertain? Are accreditation standards ethical?

Nurse educators have a responsibility not only to the patient and their students but also to the specific school, college, or university with which each is affiliated. This responsibility has many facets. Functioning within the political structure of an educational institution can indeed be challenging. Nursing programs in the United States are often viewed as high-cost, low-yield programs. Faculty must be fiscally conscious and willing to assess the consequences of their funding requests and yet mediate tensions generated by their emphasis on quality education in view of forces that are less than sensitive to the unique constraints of nursing education.

Other disciplines within the collegial setting in the United States frequently do not understand the faculty-student ratios of nursing in the clinical setting. When there can be 30 students, or even 200, in a history class with one instructor, it can be difficult for nonnursing faculty to understand why there can not be 200 students, or even 30, in a clinical nursing class with one instructor. Additionally, some administrators and faculty do not understand the critical differences between nursing education and quality nursing education. In such a dilemma, nursing educators must represent themselves fairly, and yet be purposefully creative in their approaches to clinical teaching. They have a responsibility to the student for learning, to the patient for the provision of safe, effective nursing care, and to the institution to maintain its viability and integrity. They must be responsible, accountable, and competent, helping institutional authorities to understand and trust their decisions.

Nursing education, as with any human endeavor, is replete with ethical dilemmas. However, nurse educators must set forth a sound, enduring ethical foundation upon which decisions can be made. Although a code of ethics for nurse educators has not been formulated, the following one is submitted for your consideration and as an impetus for dialogue.

A Code of Ethics for Nurse Educators

Preamble

The code of ethics for nurse educators is based on the premise that each person involved in nursing education is unique and has the right to have that uniqueness valued. Nurse educators are responsible for their choices and for adhering to ethical principles when participating in nursing practice, nursing education, and nursing research. They have a responsibility for both quality nursing care and effective nursing education, without discrimination with regard to race, color, religion, socioeconomic status, nationality, age, or sex.

1. Nurse educators will assume the responsibility and accountability for their actions in the practice of nursing and in the education of students.
2. Nurse educators will respect the rights of patients,[1] students, and colleagues to exercise freedom of choice.
3. Nurse educators will strive to promote critical thinking, meaningful interactions, and quality nursing care.
4. Nurse educators will assist the student to become competent in the practice of nursing and to became responsible ethical decision makers.
5. Nurse educators will maintain the confidentiality of matters relating to each person with whom they have contact.
6. Nurse educators will accept the responsibility for maintaining their own competencies and endeavor to safeguard the patient and the student from the incompetent.
7. Nurse educators will practice and instruct within the scope of their competencies.
8. Nurse educators will safeguard the rights and dignity of individuals in the practice of nursing and nursing education.
9. Nurse educators will participate responsibly within the academic setting.
10. Nurse educators will demonstrate respect for the student as a person and as an interdependent contributor to the profession and to society.

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[1] The term patient is used for brevity, but implies patient, client, and/or significant others

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Social and Role Constraints on Ethical Decision Making by Nurses in Hospital

A. J. Davis

1 Introduction

In this paper I shall use the words "ethical" and "moral" to mean the same thing. Ethics or moral philosophy focuses on such concepts as rights, obligations, virtues, etc. The ethical theories and principles which I use in my thinking and work have evolved in what is usually called the Western philosophical tradition. This tradition has benefited from many thinkers such as Plato, Aristotle, Kant, Mill, and many others. A developed ethical theory provides a framework within which an individual can determine morally appropriate actions. Two such theories that are used by health professionals are: (a) utilitarianism and (b) deontologic theory. Utilitarianism says that the right depends on the good. That is, what is right is that action which maximizes the greatest good and least amount of harm for the greatest number of persons. Deontologic theory says the rightness or wrongness depends on the nature or form of these actions in terms of their moral significance. There are other ethical theories, and the two mentioned are far more complex then I have indicated. I mention them only to indicate that there is a body of knowledge, ethics or moral philosophy, which can help us to structure the ethical dilemma in order to form a dialogue and to debate it.

Nursing ethics or health care ethics is applied ethics, in that we take theories and principles from moral philosophy and apply them to several interrelated areas:

1. clinical,
2. resource allocation,
3. human experimentation, and
4. health policy.

An ethical dilemma is any situation of conflicting moral claims. For example, it's a situation in which one both ought to do something and ought not do that same thing. The conflict can be between two moral principles, between patient's rights and professional's obligation, between one's professional obligation and one's own values, etc. Ethical dilemmas are complex, but ethical theory can help us to deal with them in a more systematic way.

Much in the health care ethics or bioethics is written for the physician. This literature assumes a special type of contractual relationship - historical, social, legal, ethical - between the patient and the physician. There is a paucity of philosophical considerations as well as systematic data on ethics of nursing, although the situation is better than it has been in the recent and distant past.

Ethics as a discipline has several parts. Normative ethics guides the philosophical considerations because it asks which actions are worthy of moral consideration and why. Descriptive ethics provides systematic data, since it consists of factual investigation of moral beliefs and behavior. My remarks fall into this second category of descriptive ethics. The code for nurses says that the nurse's first ethical obligation is to the individual patient. The ethics here are normative ethics. Descriptive ethics raise questions about whether, to what extent, and under what conditions nurses actually perform according to their code of ethics. It examines how nurses interpret their code.

Nurses have multiple ethical obligations. They are obligated to the patient, the hospital, the physician, and to their own professional code. As long as these obligations mesh there is no ethical dilemma. However, when what the nurse ought to do toward one pary conflicts with what she ought to do toward another, then she confronts an ethical dilemma.

I undertook a survey in which I collected data from 205 nurses. The methodology was an open-ended questionnaire format. The rationale for this approach was to have the nurses themselves indicate to what extent they understood the concept of ethical dilemma and to determine what types of dilemma they confront.

2 The Findings

The majority of the 205 respondents in this survey were young staff nurses who had a good grasp of the concept of an ethical dilemma. To the extent that this basic understanding translates into an articulated ethical stance, these nurses are in a better position than most to make their ethical concerns known in the two most frequently occurring dilemmas (prolonging life with heroic measures and unethical/incompetent activity of colleagues) as well as in other ethical dilemmas confronting them. All participating nurses, regardless of educational background, described the same types of ethical dilemma, but diploma nurses tended to be more specific in their description, often limiting it to only clinical issues and especially those immediately present in their work situation. Diploma nurses indicated that they tended to more often disagree with physicians on ethical issues than did degree nurses. This may be due to the fact that diploma nurses had worked longer or it may have something to do with the specificity of their descriptions. That is, when one focuses over time on selected ethical issues, one can and does take issue with decisions made. Younger nurses were more apt to experience difficulties around ethical dilemmas with patients, families, physicians, and institutions than were older nurses. The reasons for this remain speculative without further data. Perhaps younger nurses have less investment in the institution and those people in it than do older nurses or perhaps they are less "burned out" than older nurses and still have the idealism of youth. Also, of course, it may be that younger nurses do not have as much experience with these situations and therefore do not perceive them in their multidimensional complexities.

3 Social and Role Constraints

Davis and Aroskar [1] raised numerous questions regarding the extent to which nurses in complex health organizations can act as moral agents. Murphy [2] summarizes the situation by saying that a nurse is morally obligated to recognize the rights of the patient as an individual, but as "an employee in a health care institution she is often subordinate to the administration and, hence, must uphold the utilitarian goals of the institution: the greatest good for the greatest number."

When I have conducted ethics rounds with intensive care unit nurses as well as with other nurses, both in acute and chronic care, it has become apparent to me that many nurses, although generally aware of the ethical dilemmas confronting them, remain inarticulate due to their inability to reason ethically and to make their ethical stance known in a rational manner. The fact that these nurses, often young, female, and employees in health facilities, present a sentimental or emotional reaction tends to discredit them and allows others not to take them seriously. This situation can only make for low morale among staff.

The inability to reason through an ethical dilemma and to present an ethical stance is one major constraint for nurses. However, ethical reasoning can be learned because it depends on a body of knowledge which has been developed.

Another constraint is the nurses' social role in hospitals. And here I limit my remarks to the hospital setting, since that is where over 50% of all nurses work.

In examining social roles in hospitals the fact that the majority of the personnel are women and employees must be considered. Medicine, as a professional group, dominates the health delivery system. At the same time, however, medicine has become increasingly dependent on these nonphysician groups, referred to by some social scientists as semiprofessionals, characterized by a lack of strong reference group orientation to colleagues and therefore without a generalized colleague group as a source of norms. This situation can act to maintain the status quo of the hierarchical order among physicians and other health care personnel, in that these semiprofessional groups are more willing to accept an administrative superior as their norm source. Simpson and Simpson [3] believed that this pattern was due to the prevalence of women in the semiprofessions, who can be characterized as being more amenable to administrative control, less conscious of organizational status, and more submissive in this context then men.

Women, socialized in most societies, or at least in patriarchal ones, have historically been placed in a secondary position. To the extent that this discrimination continues, it affects social situations in hospitals. These so-called semiprofessionals, such as nurses, assist the physician in scientific tasks and function to overcome inadequacies in the medical scientific method. One way they do this is by preventing certain information from reaching the patient and his family. Essentially, these semiprofessional groups are expected to react with moral passivity to their knowledge of hospital events. Such expectations can mean that nurses who continue to work in hospitals are either comfortable with this state of affairs or experience low morale and burnout. If either is the case, then it is possible that involvement in and concern about one's own and other's ethical or unethical decisions can easily be viewed as concerns beyond the call of duty. This can act as a social constraint in ethical decisions. These comments focused on nurses in hospitals are not intended to imply that these are evil people interacting with the world in bad faith. They do draw attention to the fact that given the organizational structure of hospitals, the division of labor and the hierarchical ordering of personnel, social constraints are built in.

In hospitals when an individual worker or a group comes to grips with an ethical dilemma, often the risk/benefit ratio comes into play with regards to the formal and informal reward/punishment system operating in the institution. The major question becomes: Can semiprofessional employees, who function within this social structure as buffers or sponges between the bureaucratic system and the patient, risk raising ethical issues, especially if they involve those in superordinate positions within the system? The social structure of the hospital itself is a social constraint.

Emile Durkheim, the French socioligist, makes the point that professionals are part of a moral community. Social links develop not only to their clients and colleagues in their own profession but also to other groups with whose activities their skills must dovetail. The legitimacy of their contribution, however, must be acknowledged by others. Being labeled "semiprofessional" can inhibit such acknowledgement, can maintain the formal power structure, and can impede vital interchange on ethical and other issues central to good health care.

4 Situational Characteristics

In examining the ethical implications of the hierarchically ordered bureaucracy of the hospital, we can learn from some of the research done in the fields of social psychology and moral development. The research I am referring to was conducted in the United States, so caution must be used in generalizing to other sociocultural settings. The fact remains, however, that ethical or unethical behavior occurs in a social context in all cultures.

An important question for us to consider is what factors influence the way we behave in a moral situation. Although it is sometimes difficult for us to come to grips with the notion that we are in part creatures of our environment, the difficulty increases when we examine the idea that some moral behavior is situationally determined. This is due in part to the fact that our conception of human responsibility is largely based on the assumption that the individual is responsible for his behavior. Nevertheless, analysis of the literature to determine whether morality is more strongly influenced by personality (beliefs, values, attitudes, etc.) than by situations has had several writers conclude that the latter are far more powerful influences [4, 5]. Nowhere are the data supporting the importance of situational determinants of moral behavior more compelling than is the reality of and research on the capacity of people to inflict great harm on others [6].

Clearly, situational characteristics are powerful determinants of how we respond to ethical dilemmas. The findings show that the presence of others, the possibility of disapproval, and the awareness of threat (such as loss of job) can inhibit us from acting. This can serve as a major social constraint for nurses in hospitals given the hierarchically ordered bureaucracy of that institution. It seems that our ethics or morality is a complex social phenomenon which is as determined by the characteristics of the situation in which we find ourselves as by our belief system and our personality characteristics.

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A Simulation Game: A Tool for Teaching Ethical Decision Making to Student Nurses in Israel

N. Wagner

The simulation game "Committee on Nursing Ethics" was created to facilitate teaching student nurses the process of moral and ethical decision making, and to raise the level of moral judgment. The theoretical framework of this work is the cognitive-developmental mode of thought as it applies to each individual [4, 6, 7]. Both theorists concern themselves with the problem of growth or change in the area of moral judgment.

Nursing practice brings the nurse into close and intimate contact with patients in a variety of settings. This makes her particularly vulnerable to the ethical conflicts that arise in the course of her daily work. All three kinds of decision-making, dependent, independent, and interdependent, may become conflict-laden for both the student and the practising nurse. Moreover, new developments in science and technology affect nursing practices and lead to increasingly personal and professional value conflicts. For the purpose of training student-nurses in the process of moral and ethical decision-making, the writer of this work selected the simulation-game method, under the assumption that games would capture the students' attention and encourage them to learn more. A simulation game is a structured interaction among players who operate under an established set of rules to achieve a goal [1, 2]. The simulation game developed by the writer has two basic features:

1. It represents a real-life situation which requires the student-nurse to make an ethical and moral decision.
2. The class is turned into a "Committee on Ethics," which reviews the conduct of a fellow nurse who was faced with a moral dilemma and acted according to her judgment.

1 The Game

The class is turned into teams: "committees of ethics." All the participants review the same incident where a fellow nurse was faced with a moral dilemma and acted according to her judgment.

2 Equipment

Each team receives a kit which contains:

1. The game instructions
2. The International Council of Nurses Code of Ethics [5]
3. A board with the Star of David representing the decision-making (D-M) model (Fig: 1) [3]

4. One envelope containing the incident and its outcome on the back (to be placed in the center of the board) and six triangles which have the judges' answers for each step of the D-M process on the back. Each player receives a D-M form to be filled in individually and one for the team's decision. The game is played on three levels: individual, team, and class.

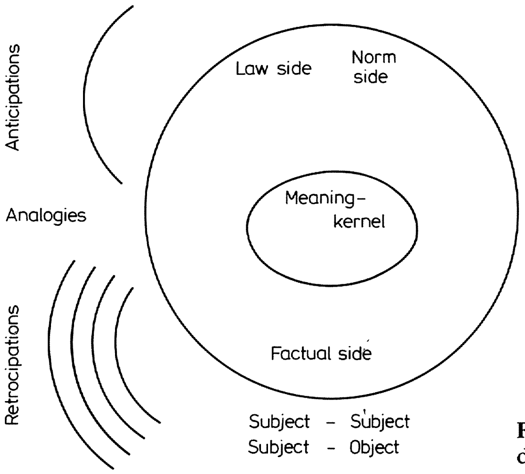

Fig. 1 Star of David representing the decision-making Model

3 Playing the Game

After a general introduction by the teacher of ethics, the purpose of the game, the rules, and a presentation of the code of ethics, the class is divided into teams of no more than five members each to ensure active participation and to prevent a silent audience.

Each of the team reads the same incident and then each player works individually on the first step.

3.1 Defining the Problem

Most players have difficulties in defining problems. Some summarize the incident, others write down the course of action. We use the "if - then" method of defining the dilemma, i.e., to distribute medication or to refuse to distribute medication the nurse believes might harm the patient. If she will obey the physician's order she might then do harm.... On the other hand, if she will not, then she may be accused of interfering with and disobeying the physician's orders.

3.2 *Clarifying Personal and Professional Beliefs*

Personal beliefs: each player writes the principles which guide him, for example, "keeping a promise" or "doing no harm" or "truth telling." Professional beliefs: each player goes through the code of ethics and looks for guidelines for professional conduct.

If he comes across conflicting concepts he has to comment on them. (The nurses' primary responsibility is to the patient versus the nurse sustains a cooperative relationship with co-workers.

3.3 *Alternatives for Action*

Each participant selects a varity of alternatives for action and grades them as good, average, or bad. This was done to encourage the student to look for additional alternatives and to avoid looking for only the conventional, safe one. At this point the team is asked to compare notes, discuss findings and reasons, and to come to a team decision. Consensus is not required.

3.4 *Decision for Action*

The team decides together on a course for action. Then they check the back of the triangles and discuss their findings with the judges and comment on them.

3.5 *Issues for Discussion*

Here the participants write all the issues needed to be discussed in depth, like truth telling, conflicts of rights, multiple loyalties, and others.

3.6 *Generalization and Policy Making*

The players are asked to write down other incidents representing the ethical problem discussed, to broaden their experience. In our opinion, many of the dilemmas could have been eliminated by correct policies. We encourage the players to suggest policy guidelines. The time frame for all the above steps is 1 hour. The final 30 min is dedicated to class discussion that will compare D-M processes and analyze in depth one or more of the steps or issues discussed above.

At each session a different incident will be played. It is recommended that team members be changed each game.

4 Evaluation of the Game: Student Comments on the Game

The effectiveness of the simulation game method in teaching ethics was tested in an experimental study [8].

Sixty-six first-year student nurses from two different nursing schools participated in the study and were assigned at random to two comparable study groups. The experimental group used the simulation-game method. The control group learned by the conventional method: lecture and discussions. Moral judgment was tested before and after the experiment. Knowledge in ethics and evaluation of teaching method were tested after the experiment.

The main findings of the study indicate first that there is no significant difference in the level of knowledge and relativistic moral judgment of the two groups, although the participants in the game showed a tendency to developing a higher level of moral judgment than the participants in the conservative teaching group. The second finding from the study was that students in the experimental group reported significantly greater enjoyment in the learning process than those learning through a conventional method.

Students' comments on the game:

"The class was fun." "It was our class, our input, discussion continued long after class adjourned." "Every one participated, we listened to each others' ideas and reasons."
"We understand now what ethical behavior is and the use of the code as guide for professional behavior."
"The written form was evaluated and I could follow my own progress." "I will never forget the incidents we played." "Through playing the game I feel more prepared to cope with ethical problems in real work settings." "The teacher was a resource person and an advisor rather than a preacher."

5 Summary

Today the game is used in schools of nursing and other educational programs in Israel. It should be remembered that the game was developed as a tool to facilitate for the student nurse the process of ethical decision making and not as an end in itself. It has to be used intelligently, since even a fun game used repetitively could be boring.

In conclusion it may be said that student nurses who participated in the game rated it as a more enjoyable and effective method through which they learned the moral decision-making process.

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Treatment

A Foundation for Nursing Ethics

S. M. Roach

My reflections on caring have evolved primarily from a philosophical and theological perspective. The following conceptualization, although tentative, is the result of these reflections.

1. Caring is an essential human attribute.
2. An individual cares not because he or she is a nurse but because he or she is a human being.
3. One becomes fulfilled as a human being to the extent that one's caring capacity is called forth, nurtured, and appropriately expressed.
4. Caring is not simply an emotional or attitudinal state. It is a total way of being, of relating, of acting; it is a quality of investment in the other - person, idea, project, thing, or self as "other" - in which one expresses self most fully, and through which one touches most intimately and authentically the core meaning of human existence.
5. The capacity to care, while almost indestructible, may, nonetheless, be suppressed or repressed when circumstances or events inhibit its growth, and/or militate against its natural expression.
6. Religious beliefs and theological insights are important in highlighting the moral significance of human actions. The beginnings of nursing were nurtured in the Judeo-Christian and other religious traditions where caring was seen as a participation in the life of an all-loving, all compassionate God.
7. Nursing, existing in contemporary society where Judeo-Christian and other religious values are in sharp tension with a prevailing secularistic and naturalistic ethic, is calling into question some of its traditional values. One of the values being challenged is the centrality and professional significance of the concept of caring.
8. Individuals select nursing as a career because they want to help people.
9. A commitment to nursing, with the satisfaction and fulfillment which it brings, presupposes the ability and the freedom to care.
10. The human capacity to care is "professionalized" in nursing through the acquisition of those skills - cognitive, affective, and psychomotor - required for the performance of prescribed nursing functions.

11. Caring is "operationalized" in nursing through the specific attributes of compassion, competence, confidence, conscience, and commitment.
12. Caring is not unique to nursing in the sense that it distinguishes nursing from other disciplines, e.g., medicine or social work. Rather, caring is unique to nursing in the sense that it is that which uniquely qualifies, as nursing, all the nurse does in his or her capacity as a nurse. (Caring is not simply the performance of a task or doing "things" to people.)
13. Preparation for nursing which seeks to professionalize the student's human capacity to care and to operationalize caring in ways specific to professional practice presupposes a nursing curriculum which is holistic and a nursing practice setting where caring models are visible.

2 Elements of Caring Behavior

As a result of much reflection on caring as it is communicated in the behavior of a nurse, I came up with the following elements, the *Five Cs*: compassion, competence, confidence, conscience, commitment. Each of these elements represents a profile of attitudes, skills, and knowledge. While not mutually exclusive - there is a sense in which each element presupposes the others - looked at singly, they do serve to identify some of the specifics of caring behavior.

2.1 Compassion

Compassion is a way of living born out of an awareness of one's relationship to all living creatures. It engenders a response of participation in the experience of another, a sensitivity to the pain and brokenness of the other. It is a quality of presence which allows one to share with and make room for the other [7, 18].

The word compassion is derived from the Latin *paticum,* meaning to suffer with, and it involves us going

> ...where it hurts, to enter into the places of pain, to share the brokenness, fear, confusion, and anguish. Compassion challenges us to cry out with those in misery, to mourn with those who suffer loneliness, to weep with those in tears. Compassion requires us to be weak with the weak, vulnerable with the vulnerable and powerless with the powerless. Compassion means full immersion in the condition of being human (H.J.M. Nouwen 1980, Compassion, unpublished manuscript).

Compassion is not a "commercialized" or a "calculated" form of kindness. It is not simply acquired by skills and techniques. One cannot get a Ph. D. in compassion. Compassion is more than mere sympathy and emotional attachment: it is born out of an experience of solidarity with the human family and an identification with the human condition [18].

2.2 *Competence*

Competence is the state of having the knowledge, skills, energy, experience, and motivation required to respond adequately to the demands of one's professional responsibilities.

Compassion, which is indispensable to the caring relationship, presupposes and operates from a competence appropriate to the demands of human care. While competence without compassion can be brutal and inhumane, compassion without competence may be no more than a meaningless, if not harmful, intrusion into the life of a person or persons needing help. The competence we are speaking about in a caring model of nursing is of a high order. It recognizes knowledge and skill as power, but a power uncontaminated by the destructiveness of rivalry and competition.

2.3 *Confidence*

Confidence is that quality which fosters trusting relationships. We are attuned to the significance of trusting relationships in nursing. But we are speaking about a very special quality of relationships - the kind of confidence which fosters trust without dependency, communicates truth without violence. It is a confidence which creates respect without paternalism and ensures a relationship which does not compromise the freedom and independence of clients by rendering them powerless.

2.4 *Conscience*

Conscience is a sensitive, informed sense of what is right and wrong, a compass directing one's behavior according to prescribed moral standards.

Professional practice, and I am using the word "practice" in a very general way, demands a keen ethical and moral sensitivity, an ethical and moral sensitivity which is the product of disciplined study and reflection. The nurse who "cares" sees the development of a refined, informed, moral conscience no longer an option, but a professional responsibility.

2.5 *Commitment*

Commitment is a complex affective response characterized by a convergence between one's desires and one's obligations, and by a deliberate choice to act in accordance with them.

Commitment is a quality of investment of self in a task, a person, choice, or a career, a quality which becomes so internalized as a value that what one is obligated to do is not regarded as a burden. (There is an interesting similarity between Milton Mayeroff's analysis of caring, particularly his discussion of devotion [17], and Krathwohl et al's discussion of the place of commitment as an affective behavior on a continuum of internalization [12].

3 Caring and Levels of Moral Discourse

In his work, *Reason and Conduct,* Henry D. Aiken proposes a way of analyzing the levels at which moral discourse proceeds [1]. Aiken shows that there are at least four distinctive levels upon which such terms as "good," "right," and "ought" are used, and he discusses the role of judgment at each of these four levels.

3.1 Moral Discourse Levels

3.1.1 The "Expressive-Evocative" Level

This level refers to the initial response to a situation, such responses including pleasure, joy, dislike, etc. "We see something and like it; we hear something and dislike it; we think of someone and are at once attracted or repelled, we know not why" [1, p 68]. These expressions, Aiken suggests, serve merely to vent our emotions. They are conventional expressions of personal feelings. Applying to these reactions such labels as "good" or "bad" or questioning their truth or validity is decisively inappropriate.

3.1.2 The Level of Moral Rules

It is at the level of moral rules that questions about the rightness or wrongness of certain actions, of what one ought to do in specific situations, begin to be asked. This level includes two phases, one having to do with statements of fact about means and consequences involved - the patient ought to have been given accurate information - and the other identifying the moral rules by which such means and consequences can be appraised - one ought to tell the truth.

Moral rules, according to Aiken, specify "certain types of behavior which ordinary non-deviant persons within a given community would approve and which demand that the addressee, insofar as he is "normal," likewise approve and, if appropriate, act accordingly" [1, p 74-75]. The following are examples of such rules: don't kill; don't cause pain; don't steal; don't lie; or, stated in positive form, protect life; relieve suffering; respect the property of others; tell the truth; keep promises.

3.1.3 The Level of Ethical Principles

At this level one questions why a moral rule is right and inquires into the basis for saying that a particular course of action is indeed right or wrong. At the ethical level, one considers principles on a higher level of generality than that of moral rules. They include, for example, such principles as the principle of beneficence - to do good and prevent harm [8, p 45]; the principle of nonmaleficence - to do no harm; the principle of distributive justice - to treat human beings as equals [8, p 49]; the sanctity of life principle - human life is precious, even mysterious, and is worthy of respect and protection [11, p 18]; the principle of respect for persons - the human being is of incalculable worth, such worth not determined by utilitarian concerns.

The role of ethical principles is not to tell us precisely what to do in a particular case, but rather to provide us with standards for appraising lower-order rules. Ethical principles function like a compass. They provide for a general direction rather than the specifics of a road map.

3.1.4 The Post-Ethical or "Human" Level

Aiken suggests that the problem raised at this level is best represented by the question, "Why be moral?" There is a fundamental difference between this level and levels two and three. At this fourth level it is as if we were asking questions of morality which are beyond the functions of morality to answer. But, as Aiken observes, "man is more if also less than a moral being. And, as such, he may have questions to ask of morality which it itself is unable to answer" [1, p 85].

3.2 The Caring Paradigm and Aiken's Levels

I should now like to share a few thoughts on the way in which the proposed elements of caring - compassion, competence, confidence, conscience, and commitment - may be viewed within the context of Aiken's levels of moral discourse.

First, in looking at the expressive-evocative level, it is important to remember that Aiken is saying that judgments about the validity, rightness, or wrongness of specific reactions at this stage are inappropriate. The reaction a person might have is merely a reaction, a reflex. When one looks at behavior from a moral and ethical perspective, however, a reaction at this level does provide cues about the moral demands of a particular situation, as well as about the attitudes and values of the person reacting.

In itself, the initial expressive-evocative reaction to a particular situation communicates an ethical and moral sense. In fact, the initial reaction is usually the first signal that something is not right, that what is happening or has happened does or does not *fit* expected moral standards, that a particular situation is consistent or inconsistent with the moral sensitivities of the one reacting. And, just as a reaction of noticeable intensity to a particular situation or happening is expressive of an underlying value system, so also is no apparent reaction at all. The expressive-evocative level may be neutral in so far as its objective moral "texture"is concerned; it does, however, communicate something meaningful about the nature of the situation and of the response of the person reacting to it.

Although we may not know the "why" of a given response, caring is operative at the expressive-evocative level. The nature, timing, and intensity of a reaction can be assumed to be influenced by the quality of one's compassion, the breadth of one's competence, the nature of one's relationships, the sensitivity of one's conscience, and the degree and internalization of one's commitments.

Second, when one begins to question a situation and the reaction to it, one goes beyond the expressive-evocative level, and a more active process of inquiry is initiated. It is important to interject here, however, that this activity does not take place in a vacuum. The very questions themselves are shaped by the kind of identification with the issue or problem, the degree of competence in discerning the significance of the issues, and the possible approaches which may be used to respond effectively. The compassionate person rates high on sensitive identification. If he or she does not have a given level of competence, however, the rating on discernment and appraisal of possible solutions is considerably lower. In fact, the appropriate and critical questions may not even be raised. Trusting relationships influence the quality of strategies considered as well as point to the range of options available for planning outcomes. At this second level, the moral reasoning process is inspired, moved, and directed by a specific caring stance, with specific affective and cognitive determinants.

At the third level - the level of ethical principles - caring skills take on a sharper degree of sophistication. In the initial discussion of the elements of caring, namely, compassion, competence, confidence, conscience, and commitment, it was noted that these elements are not mutually exclusive. In a sense one element presupposes the others, supporting the view that an authentic caring response is always somehow compromised when one of these elements is lacking.

I suggest that there is a sense in which one's unique caring capability influences the choice of ethical principles one makes in the first place, and certainly modifies the degree to which one is able to adhere to them. The elements of caring are operative at both levels, that is, in the discernment of principles and in the commitment needed to adhere to them.

One might want to examine how the caring response enters into practical discourse on ethical issues, viewed from different perspectives, for example, from a utilitarian or formalist position [5, 6, 19].

The process involved at the third level of moral discourse, the level of ethical principles, reflects in distinct ways the elements of caring. The quality and depth of compassion and the degree of participation in, and identification with, the situation involved influence the interpretation one makes of one's obligations - past, present, future. Competence in understanding the issues; in analyzing significant components; and in identifying, morally appraising, and choosing principles also shapes the position one eventually takes on an issue. These activities, in turn, influence and are influenced by relationships and by the movement of one's conscience. Commitment to discern, choose, and live by appropriate principles provides the stability that integrity in the moral life requires.

As indicated above, Aiken suggests that at the fourth, or post-ethical, level we find ourselves asking questions which are beyond the function of morality to answer. But Aiken also implies that the questions, nonetheless, are "askable," and need to be raised. Questions such as "why be moral" (and I would add "why be caring") are in this category.

At the fourth level of moral discourse, the person is drawn into a contemplative vision of human concerns and moral issues. It is at this level that the rules and principles are moved to another perspective of "reasonableness," where contemplative knowledge, aided, for example, by theological insights and by personal and shared faith experiences, contributes to the process of ethical decision making.

At this level we are asking the question, "Why be caring at all?" This is a question which elicits and draws upon insights on the meaning of human being and on the relationship of these insights to the meaning of human care. At this level the five

Cs find their ultimate but seemingly unlimited horizon, immeasurable but comprehensible; this horizon is intangible and unquantifiable, but open to, and influenced by, contemplative vision [3].

The questions "why be moral" and "why be caring" have to do with ultimate ends and purposes. Perhaps the answer to these questions is "beyond reasoning" because the answer is already *given*. The answer is not to be *determined*: the answer is to be discovered.

Aristotle says in his *Ethics,*

> We deliberate not about ends but about means to attain ends: no physician deliberates whether he should cure, no orator whether he should be convincing, no statesman whether he should establish law and order, nor does any expert deliberate about the end of his profession. We take the end for granted, and then consider in what manner and by what means it can be realized. [2, p 61].

The nurse does not "deliberate" about whether or not she ought to care, for to care is the end of nursing. She deliberates on how caring can best be accomplished.

4 Conclusion

Caring is living in the context of relational responsibilities. This is really what ethics is about. Whether we are primarily practitioners of nursing, educators, researchers, or administrators, our activities involve us in human relationships which imply responsibility - responsibility to our patients, clients, peers, and colleagues. To the extent that these relationships are characterized by the qualities of human care, to that extent are they sensitive to appropriate ethical norms which provide for and ensure relational responsibility.

Paul Ramsey, a noted contemporary ethicist, speaks of these norms as canons of loyalty, using the biblical notion of fidelity to covenant as the model [24]. Ramsey considers the moral requirements of medical ethics as only a particular case of the moral requirements governing the relationships between human beings.

> We are born within covenants of life with life. By nature, choice, or need we live with our fellow men in roles and relations. Therefore we must ask, what is the meaning of *faithfulness* of one human being to another in every one of these relations? This is the ethical question. [24, p XII]

Caring is never simply a job I must do, and I do not simply "give care." Caring is a way of being, of relating, and of perceiving my professional responsibilities, and it is expressed in deliberate actions grounded in appropriate knowledge and learned skills. Caring is more than an emotional outlook or attitude. It embraces qualities of mind, breadth of expertise, and determination of will. And it is, in fact, a particular choice of serving in which I find my own fulfillment.

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Ethical Imperatives in Nursing

S. S. Rosario

1 The Importance of the True Concept of the Human Beeing

Personally, I feel that the figure of Florence Nightingale has become greater as I have become more and more acquainted with her life and her writings. She made our profession great; not only did she lead it to a total technological reform, but with her concept of man, she also gave it a magnificent ethical meaning, based on the natural law. With this contribution, she exalted and protected nursing from the treat of degradation and servility. I feel, therefore, very united to a woman who through upright rebelliousness showed us a right way, an extensive and generous way, in which so many noble options are possible.

Perhaps, at present, these ethics have a bad reputation. The nonethical aspect of certain positions totally condemns natural ethics and those who believe in these principles, upholding the right to live. We are accused of being "fanatical zealots of life." If we demonstrate our convictions through arguments of reason, we are denounced as being "rigid moralists."

In the International Council of Nurses *Code for Nurses* of 1973, approved in Mexico, in the section which corresponds to the ethical concepts applied to nursing, the following is said: "The respect for life, for the dignity and rights of the human being are essential conditions for nursing."

If nursing wishes to be truly human, it must take into consideration the whole person. Or, said in another way, so that nursing not lose its substantial qualities, it must be based on the concept of the being and nature of man. A thorough knowledge of *what man is* leads us to what is objective. This objective nature of man also carries with it objective demands, which must be respected. If the concept of man includes only partial aspects, then one takes as the starting point what the human person *is not,* and even with good will the treatment which nursing gives (on this topic) can become a lamentable error. I do not ignore that perhaps someone will think that the concept of man as a being composed of matter and spirit with a transcendent destiny is a "prejudice." But what I can assure is that when one has as the starting point this consideration of the human being, then nursing encounters a value which ennobles and perfects the person who possesses it, and this consideration of the human being also explains the conduct of high moral content of so many consistent professionals engaged in this lofty conception of man. The concept which each nurse has of man determines his or her moral spirit.

2 Ethical Concepts

Throughout the years, it has become general opinion that the ethical problems of nursing are very complex and permit diverse and equally valid solutions. This adaptation to the ethical pluralism prevailing in a democratic society is such that professionals, who possess an unyielding firmness based on a demanding conception of ethical reality, frequently see themselves labeled as being intransigent for their resistence in collaborating in the permissive practices already admitted as ordinary administration in our profession.

Ethics is far from the positivism which tries to reduce it to pure factual content, void of all absolute normativity. It is also far from the formalism which situates morality in something perfectly autonomous, based in itself, and independent of natural finality.

The principles and moral norms which ethics indicates have as their source the rational and free nature of man, such as it appears through the light of reason. The principal source of ethics is human reason, since it encounters and knows the universal moral principles, and from certain of these are derived the rest of the principles of this science.

Therefore, there are three ideas to which attention must be paid:

1. The morality of nursing must be based on being and nature.
2. It must be in conformity with right reason, with finality, and be ordered according to values. Ethics does not live in things, but rather in persons, in their judgments, in their personality, in their conception and realization of values.
3. Ethics must be rooted in what is transcendent.

3 The Ethical Formation of Nurses

As has been stated, ethics lives in persons. Ethics as a science has two dimensions: theoretical and practical. These two should be present in the plan of formation. I want the need to promote a suitable faculty to be noted, since experience demonstrates that much more than what is taught, what matters is what is really learned. If we ask ourselves if our students acquire a total vision of their professional work, it is possible that we will arrive at conclusions that will make us see as urgent the need to prepare a faculty of scientific and human quality, that will know how to transmit the ideals of our profession reflecting them in their own person. The basic problem of any professor of ethics resides in his decision to choose between reductionist doctrines and ethics based on natural law.

Ethical principles are also a source of progress in nursing because they prevent easy solutions; they prompt one to the solution of difficulties through other ways distinct from the excessively simple ones of killing, of doing abortions, of sterilizing, etc. They also prevent nurses from being simple executors of certain orders demanded by the patient or by a state or by certain pressure groups. The result of all this has been that some of us, educators in nursing, feel urged to pay due attention to the ethical formation of nurses. It is necessary that nurses know how to substantiate with reasons the ethical character of the decisions which they make. These decisions may be most varied, because there is a great variety of styles within a rich and legitimate pluralism. But we do not forget that objective ethics says that there are problems which admit many solutions, while there are others which demand adaptation to intangible principles.

As a consequence of a well-structured teaching of ethics, topics of research can be posed in the sphere of the decisions of nursing. Thus, far from an immobility, the ethical science acquired is a source of professional stimulus and progress.

The practical application of ethics is as necessary as the theoretical foundation. The possession of specific knowledge of this science is a requirement prior to the real-life situation where it is applied. We should put our students in the real conditions which will make them acquire the habit of doing good. So that this habit be developed, there must be repetition within nursing practice. For this reason, the frequent experience of practice is unavoidable. This is where the student sees, listens, and values the actual, individual situation, while he or she learns from the actions of nursing professionals who are nearby. It is truly the school of life itself which will make the student incorporate the fundamental attitudes which, by living them, through others, and among others, make the words of a teacher and the hours of study more efficient.

With respect to the work atmosphere where our students are preparing themselves, so that it really be an educational factor, there must be good organization and a high degree of planning of the tasks of nursing, close collaboration among its members, identification of criteria, help within teamwork, and a considerable level of appreciation for the ethical values in the persons of the nurses.

An example can help us to see this. In the clinic where I work, a 63-year-old patient was admitted. Seventeen years prior to this, he had been operated on for a double aortic lesion. He remained on anticoagulent treatment until the day he was admitted for a cerebral ictus. He was a farmer.

Upon his admission, the patient was fading, but he would respond correctly to stimuli and would move his extremities.

During the first 3 days, he remained conscious, but his respiratory status was becoming worse and it was necessary to intubate him and use controlled respiration.

On the 4th day, he went into a coma. The nursing care which was applied day after day was exhaustive and specific for each system. The duration of his coma was 35 days.

The wife remained in the clinic practically the whole time, awaiting news as to changes in her husband's condition during the day or the night.

Despite moments of natural discouragement due to the constant, grave situation of the patient, the nurses of the unit put their best effort forward in maintaining the patient in the best, basic conditions so that he be able to rise above the complications whenever they presented themselves.

These constant and multiple complications were:

- Acute renal insufficiency, which was treated with peritoneal dialysis. The recuperation was total.
- Specific complications of respiratory insufficiency, infection, atelectasis, etc. He was treated with intubation, tracheotomy, aspirations, artificial respiration. He totally recuperated.
- Physical incapacity, due to the long period in bed, which was solved through rehabilitation. At the opportune moment we began to feed him through a nasogastric catheter.

The supervisor of the unit commented to me that all this had entailed a serious effort for them, but that it had been worthwhile. The patient remained in the hospital for 91 days.

In a nursing conference, when one examines the case of a patient like this, the question always arises: "Are we not hoping for the impossible with this patient?" But there is always the same response: "And if he still responds?" And once again that voice urges one to fight for the life of another human being.

Human hope needs to encounter in others that profound respect toward nature, in moments in which one is unarmed, in the hands or in the decisions of doctors and nurses.

Who could think that the life of this man, with his wife, his children, his work in the fields, is not something great? Is it not, perhaps, a new chant to life?

It has deeply worried me to see that in the name of a supposed advancement in the science of nursing, some nursing schools, far from appreciating and transmitting the ethical foundations of our profession, have eliminated from their programs everything concerning ethical science. I ask myself: Who is interested in graduating classes of nurses who will assume work positions without ethical formations? Is it not possible that many see in ethics a restraint as far as their interests are concerned? Undoubtedly, it is easier to manipulate the decisions of those who lack criteria than of those who have them firmly rooted in their thought and in their conduct.

In nursing one frequently professionals who disregard not only the traditional ethical principles but who also base themselves on the concept that there is nothing intrinsically good or bad; what is sought is that students of nursing ponder the distinct alternatives of a moral problem and choose their own system of values, without reference to any moral, objective principles. This leads to relativism, the cause of grave disorders in nursing.

I am conscious of the fact that moral demands furnish their contribution to what nursing has produced as best and most beautiful for science, for the individual, and for society.

4 Legislation and Ethics

What happens when the essence of our profession is trampled on by the laws of some states which mistreat human rights? What occurs when we are asked for collaboration which runs counter to ethical principles?

Human laws, in order to be true laws, must be ordered to the common good and thus express the natural ordering of the universe. If they contradict that natural order, they are not true laws but rather a corruption of the law and lead to violence and oppression, no matter how numerous the votes which acclaim them may be. The number of votes has never determined objective truth. We can consequently say that if, in effect, the state has an area of legitimate autonomy to dictate laws and order the citizen's life, that in no way means that it can accomplish this ordering at its own free interest; on the contrary, it should always proceed taking into account the necessary reference to natural law.

Much less admissible is the radical form which makes of the state the supreme source from which all law and right issues. In this way, the simple fact that the state promotes a law as obligatory would suffice to create a right. This is the most total absolutism. This, in summary, is equivalent to affirming that human law decides and establishes good and evil, the licit and the illicit at all levels. When morality is exclusively based on human authority, is sooner or later collapses; it is thus, because it will be considered as simple convenience and rights will be considered as a weapon of power.

5 Codes

The deontological codes, the norms which regulate the professional activity of the nurse, are not an invention of our times. Codes have been accompanying the activity of the nurse for a considerable number of years, even though throughout the ages they have been pronounced in a different way.

Some deontological codes, whether they be promulgated in the form of an oath, a prayer, a treaty, or in the actual form of a code - which are commonly considered as the most important - reflect within their own sphere some fundamental principles which have always been recognized by man, although with more or less clarity, throughout the ages.

The international code and some national ones express in our times this tradition of codifying norms of conduct for nursing.

But, concretely, in these last few years, we find ourselves with a codification of norms disassociated from what is transcendent and from natural law, a juridical positivism that empties some of these codes of any content. The consensus of all nurses is bought, eliminating the points which may be more conflictive but which are, on the whole, the ones which demand a strictly deontological solution.

In one way or another, it is highly positive that there be compiled norms which support what nursing has been and is: a "service to the human race," vis-à-vis the subjectivism of the nurse who cares for the person, valiently facing the basic problems, in which the life and other values of the person are brought into play.

But codes are not sufficient; they may be there, but they are in fact ignored in many cases by the very educators of nursing.

In an age which has discovered the value of conscientious objection, the nurse has to be encouraged to know how to invoke her conscience against those who pursue others to necessarily collaborate in their immoral plans: a difficult position, but a valient one. Those who collaborate, those who accept baseness, have an easier life than those who choose the way of active resistance, but only these preserve the moral recourses which perpetuate the ideal of our nursing.

6 Conclusions

Nursing will last, as such, if, as Frankl says, we are "united through a common will," that is, accepting in our task those principal elements which, because they are true and universal, put our profession at the service of man kind in all its dimensions and give our professional conduct a transcendent, humanitarian, and scientific meaning. From all this, one concludes that ethical principles must be present as something immutable in the formation of new professionals, in each one of us, and that nursing associations, of whatever type, should be faithful receivers and transmitters. If, on the contrary, we give up in this effort to form right-minded intelligence with wills united in the service of this common meaning, nursing would then be just another thing not worthwhile being immersed in.

Professional immobilism is excluded if the ethical principles based on natural law are respected, because each one of them, being intangible, poses a serious challenge to science, which in the field of nursing, supposes that all the recourses of which it is capable be brought into play, encouraging it inevitably toward its continued advancement.

Ethical Considerations in the Care of Dying Patients

L. Hockey

1 Introduction

I would like to explore just one of the many ethical considerations which confront nurses and other health professionals in the care of dying patients. I have selected the patient's right to dignity.

My reason for this choice is that I believe it to be one of the most important, if not *the* most important, consideration; at the same time, it is one of the least understood, if not *the* least understood, concept. Moreover, the term "dignity" comes up regularly in examination answers dealing with the care of the dying and there are few, if any, textbooks which do not make reference to the need to preserve the patient's dignity. My paper is structured around three questions:

1. What is dignity?
2. Do patients have a right to dignity?
3. Are dying patients different with regard to this right and, if so, in what way?

I recognize these questions as ethical ones; but I am not a moral philosopher myself and I hope that I will get some clarification from people who are better qualified than I am.

2 The First Question Is: What is Dignity?

The term dignity, as I have already mentioned, occurs frequently but is hardly ever defined. The dictionary gives pointers but does not provide a clear-cut definition. Dignity has to do with "worth" and with "respect." Within the context of patient care I would paraphrase "preserving the patient's dignity" by "showing the patient respect in the awareness of his individual worth." It includes the encouragement of self-respect; it is the preservation of the patient's integrity as a "whole" human being, including his past and anticipated future which are part of him, and including also his relationships with significant others. The thesaurus of synonyms and antonyms gives some color to the term dignity by defining its opposite as "degradation" and the opposite to showing dignity as "undervaluing." Thus, if I do *not* preserve a patient's dignity in the course of my care, I degrade and undervalue him. Putting the matter in this form seems to make it immediately desirable to preserve dignity. Yes, we ought to, it is good; it is right. Our conduct as nurses should be directed by it. What *is* the force which directs us to conduct ourselves in this way? It is neither pure science nor pure emotion; it is a composite force; physical and behavioral sciences must play an important part, and also ideological considerations which may have their origin in religion, in politics, or in other sources of value systems. However, ultimately the force is activated by a moral judgment, by the notion of obligation, and it is moral philosophy or ethics which should be able to help to provide an analysis of these fundamental concepts. While ethical considerations alone cannot dictate or prescribe our conduct, they make an important contribution. They are a necessary, though not a sufficient, condition for the study and the understanding of human conduct in the care of patients.

3 The Second Question: Do Patients Have a Right to Dignity?

To some extent this question has already been answered, albeit in an oblique way. Before addressing it more directly, the term "right" requires some clarification. Again, moral philosophy should and can help, as long as we do not refer to legal rights alone. The right to dignity is not a legal right; it is not explicit in any legal code, at least not expressed in this way. The boundary between legal and ethical concerns is, however, blurred.

In relation to dignity, the distinction between a legal and a moral right to it depends on what one considers to be components of dignity. For example, if dignity includes the right to reject treatment, the doctor's legal duty to provide treatment may be in conflict; the converse may apply with an equal conflict between a legal and moral right. Thus, the patient with his legal right to treatment may be considered by a physician as a person whose treatment would be morally indefensible.

What is a right? Having looked at many expositions of the term in the literature, I decided to fall back on Ginsberg who wrote *On Justice in Society* [1] nearly 20 years ago:

> A right may be defined as a claim that is or can be justly made by or on behalf of an individual or group to some condition or power.

In our case it is the claim to respect by others or self. Ginsberg goes on to say:

> Distinct rights and duties are based on distinct elements of well-being.

He explains the inclusion of the words "on behalf of" in the definition to cover cases in which the subjects of the rights have not the capacity to make a claim. Ginsberg understandably links rights and duties, saying that they rest on the same ethical foundation.

> A person's right consists of his claims to the conditions of well-being; his duties of what he is expected to contribute to well-being.

It is the linking of rights with duties that takes us into the area of justice. The World Health Organization's target of access to health care for all by the year 2000, which arose from the Alma Ata Conference, clearly has in implication for the ethical rights of nations and individuals within nations; it is a target which appeals to justice in the world.

Yes, patients do have a right to dignity as part of their contract with professional carers.

4 The Third Question: Are Dying Patients Different with Regard to This Right?

My last question relates to the care of dying patients and asks whether these patients are different from others in relation to their right to dignity and, if so, in what way.

The definition of dying has exercised many people, scientists, and the caring professions for many years. The purist could argue that dying begins at birth. I deliberately refrain from using terminal illness or terminal patient because life itself is a terminal condition which carries a 100% mortality. However, for the purpose of our discussion it is important to arrive at some agreed interpretation of "dying." As professionals we are probably fairly able to recognize the beginning of the end but less able to give it valid or reliable descriptors. I am not attempting to do that either and apologize for the crude and elementary proposition that a dying patient is one who is not expected to benefit from therapeutic intervention.

Are these patients different from any others as far as their right to dignity is concerned? Detached from the actual caring situation we would probably agree that dying patients have exactly the same rights as others; we would, moreover, agree that the dignity of dying patients is more readily damaged and that it is, therefore, especially important to build safeguards into their care. What makes them different?

Going back to Ginsberg's [1] explanation of a right and its alignment to duties, a dying patient may not be able to perform his duty any longer. Can we allow rights without responsibilities and duties? Is it just to allow it? I defined dignity as having individual worth and self-respect. Does a dying patient have as much worth as a person with a future? We all know the extent to which a person's expected contribution to the national economy forms an important part of cost-benefit calculations? A dying person will make no contribution; what is his worth?

To demonstrate respect for a dying patient or to encourage his self-respect is time consuming. If a choice has to be made between giving time to a young person with a serious illness, which is expected to respond to treatment, and an elderly dying person, is it perhaps right to invest this precious commodity of time in the care of the former rather than the latter? Research has demonstrated the many symptoms of dying patients which interfere with their dignity: incontinence, bad smell, excessive pain, inability to keep themselves groomed - to mention just a few. They can all be alleviated but at the cost of time.

It is also important to consider the family. Assault on the patient's dignity affects the family profoundly, and if their dignity is offended they are not able to function as individuals of worth, giving support to the dying person and sustaining their own equilibrium.

In answer to the questions I posed, dying patients *are* different in that they can no longer perform duties to balance their rights. Special effort must be made to pay more than lip service to dignity.

The most important difference between dying patients and others is the uniqueness of the dying experience. Assaults on dignity cannot be reversed; mistakes cannot be corrected.

The question I have often been asked by students is how one can preserve the dignity of a patient against so many uncontrollable odds. Let me give you an example of what in ingenious nurse did for an old lady with a colostomy for malignancy.

This patient said:

> When I went into hospital I was a dirty old woman, I couldn't keep myself clean and my daughter was always angry with me. I was sick of myself and didn't care any more what happened. The nurses in hospital were so lovely and when they taught me how to clean myself up one of them said: "You see, the doctors turned your back passage round so you can see what you are doing. It's hard for an elderly person to clean herself after the toilet - this will be easier for you. We know you are so particular."

Her self-respect had been totally restored and the daughter was delighted. Although a novel way of introducing a patient to a colostomy, this was, in my view, a superb demonstration of the possibility of restoring self-respect and dignity.

In closing, I want to make two points and to raise two questions for discussion.

I have already alluded to my first point, that of time. Dying patients are very time consuming as far as nursing is concerned. Many of them are comatose and they are, after all, dying anyway. In view of the pressures in a busy ward, is it not right to give more time to the patients whom we want to cure?

My second point: dying patients are likely to have unpleasant and often repulsive symptoms. They cannot complain and, as their dying experience is unique, they cannot compare their care with anything else.

The care givers, such as the nurses, are human beings and may be repulsed by the patient's condition and symptoms. Depressed, confused, incontinent, smelly patients are not the most attractive subjects for care. It is only too easy to show one's repulsion, thereby often hurting the patient; it is also easy to reduce contact with the patient using 101 rationalizations for doing it. It is an assault to dignity.

The only force which keeps one going on and doing what one knows to be right is a sense of value or moral duty. My questions are: can such values be inculcated in training or should only people holding these values be recruited? What is the test anyway?

Related to this question is the following: do you think that people holding high moral values select themselves for the caring professions? I thought so until some research by Reid [2], based on observational data, showed incontinent patients being cleaned up with the aid of long-handled brushes. Perhaps the grimness of the reality outweighs the appeal of the abstract vocation.

The significance of this example lies in the withholding of one of the most effective and valuable tools a nurse has at her disposal; I refer to "touch." The patients in this instance were "untouchables" and the nurse removed herself from them literally. Are there any other tolls, abilities, skills, is there anything else that we deliberately or unwittingly withhold from our patients? Do we remove ourselves in any way from those for whom we profess to care? Do we deny them knowledge, empathy, compassion? What do you think?

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Ethical Problems in the Assessment of the Quality of Care

R. Eldar

The assessment of the quality of care aims to determine whether acceptable care is being provided. It relies on three types of information about the care - its structure, its process, and its outcome - and may be approached by studying any one of these three elements.

The approach of structure assumes that better quality of care is more likely to be provided when better qualified staff, improved physical facilities, and a sounder administrative organization exist. This approach evaluates the inputs of human and material resources available and the way in which these are organized. It entails studies of the institution's staff; its physical plant, equipment, supplies, and budget; and its organizational features.

The process approach examines how resources are being utilized and assesses whether the technical management of patients and the interpersonal interaction between health professionals and patients conforms with accepted principles and practices. This approach involves studies of the activities of practitioners as well as studies of the volume of care, the way in which ancillary services are being used, and the patterns of care.

The study of outcome addresses the output or end results toward which the resources have been used. It entails the evaluation of changes in the current and future health status attributable to antecedent care. It examines morbidity, mortality, recovery, and survival rates and measurements that reflect the restoration of function physical, physiological, psychological, and social). It also involves the appraisal of patient attitudes, such as satisfaction, health-related knowledge, and health-related behavioral change acquired by patients.

This threefold approach to the assessment of quality is possible because there is a fundamental, functional relationship among the three elements: structural characteristics of the setting in which care takes place affect the process of care, and changes in the process of care influence the effect of care on health status. Any of the three elements of care may be studied, singly or in combination, provided there is a valid relation between them and the quality of care in the given case. The selection of the element studied depends on which of its criteria and standards can more easily and more accurately be measured in the specific situation.

The element of structure, being rather stable, indicates only general tendencies and is not used as a tool of continuous surveillance. The approaches of process and outcome are the ones in common use for this purpose, and they appear to be equally valid in most cases. However, in both approaches ethical problems may arise.

In the process approach, the technical management of the case is based on norms that derive from the state of science and technology and are determined by health practitioners who also generate and control the information needed to assess them. The interpersonal interaction, on the other hand, is determined by norms that derive from the values and ethical principles that govern, in a given society, relationships among people in general and between health practitioners and patients in particular. These norms can be assessed by patients, who are also sources of criteria, standards, and information of this component of the process of care. Process can be assessed prospectively, concurrently, or retrospectively for preventive, interventive, or remedial purposes respectively. In any case, ethical problems may appear. These can arise from the inclusion of procedures that are still in an experimental stage or from withholding care that is generally viewed to be useful, even when there may be no cinvincing evidence to support this view. The incorporation of insufficiently validated prevalent practices as formal criteria and standards into an assessment program may lead to the perpetuation of possible errors on the basis of ethical considerations. Once established, such practices are not only less likely to be questioned, but it may become impossible to subject them to testing under experimental conditions.

Outcome assessments may include appraisal of immediate or intermediate elements in the chain of results during the provision of care. However, in most cases, the assessment of outcome is retrospective. It may be attempted so early that the results are not yet fully known, or so late that they have lost some of their usefulness. Adverse outcomes that are delayed raise an ethical problem of not intervening earlier to prevent such outcomes. If these can be predicted with reasonable certainty by a timely examination of process, it would not be ethical not to do so. Intervention after the event may avoid or minimize the future incidence of such outcomes, but in the meantime an unjustifiable amount of potentially preventable harm may have been done. The outcome approach enables the patient to be the primary source of information only regarding the results expressed in functional terms. However, the results of fine distinctions in physiological, biochemical, and functional state are defined, specified, and measured by experts. The assessment of outcomes will give not information about the acceptability to the patient of the manner in which the results have been attained, unless specific aspects of patient satisfaction are included among the measured outcomes.

Thus, both approaches in common use for the assessment of the quality of care and its assurance - the process approach and the outcome approach - may give rise to ethical problems. The ethical issues raised differ, however, depending on the approach used. There also is a difference among the approaches as to the extent to which patients are sources of information used for the determination of criteria and standards of data needed for their assessment. These differences may affect social policy considerations that pertain to the choice of an appropriate definition and level of quality. The practical implication of the differing ethical vulnerability of the two approaches for the formulation of these aspects of social policy lies in the possibility that inequities can arise if process criteria are used to assess the quality of care - and its assurance - received by certain population groups in a specific situation, while outcome criteria are used for other groups in the same situation. Thus, for example, outcome criteria in quality assessment and assurance have been used with the aim of controlling the costs of care. Accordingly, there may be pressure that organizations that are subsidized partly or wholly by public funds rely more on measures of outcome rather than on measures of process. If this happens, care available to people dependent on these sources of care will be of lower quality than the care provided for the same condition by another population group obtaining its care at another source. This is because services that are generally considered to be useful could be withheld under the pretext that they are not sufficiently validated or because outcome criteria were set rather low or because some outcomes may not be measured at all.

In order to minimize the influence of ethical issues arising from the assessment of the quality of care on the formulation of social policy regarding the definition of quality of care and its level, it is suggested that the same approach be used to assess the quality of care in a given condition provided to different population groups.

Ethical Issues in the Care of the Elderly Under Socialised Medicine

M. S. Macmillan

1 Introduction

I have chosen to address the subject of Ethical issues in the care of the elderly under socialized medicine for several reasons. The area of medical ethics has long been a personal interest and I am presently attached to the Edinburgh Medical Group, whose raison d'être is to discuss such topics on an interdisciplinary basis. Care of the elderly is of universal interest to those of us not in the first flush of youth and it is the subject of my current research. As for nationalized medicine, it is the system I've been brought up with and under whose aegis I have worked and under whose care I've been treated.

2 Background

It might be of interest to know that the National Health Service (NHS) was finally brought into being in 1949 [6] as part of the response to Aneurin Bevan's "5 Giants," which were:

1. *Poverty,* which was to be answered by social security, insurance, and pensions
2. *Squalor,* which was to be answered by a new housing policy
3. *Disease,* which was to be answered by the NHS
4. *Indolence,* which was to be answered by eradication of unemployment
5. *Ignorance,* which was to be answered by a new education policy

Our health service is a mixed system where the state provides health services for all and the costs are met by taxation and compulsory contributions, but those who wish to may pay for private care. While it is true that there is a service provided for all, it is also true that not all patients are treated identically.

This NHS is provided in Scotland for a population of around 5.2 million [7] which has had only minor fluctuations since 1961 and no significant change is expected up to 1991. The most important population change is the rise in the number of people of 65 years and over. In the next 15 years, those aged 75-84 will have increased by 18.7% and those aged 85 and over by 47.2%. However, it must be noted that this group will only number some 61000.[1] This weighting of elderly people does, of course, have implications for the provision not only of acute health care but also for an increased demand for long-term care, particularly of geriatric and psychogeriatric hospital places, and also community services such as district nurses and health visitors as well as general practitioners.

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[1] Registrar General Scotland, projected home population, 1977-based and unpublished figures

My present research is designed to find out what information is collected about patients aged 75 and over and how it is handled to facilitate their movement between hospital and the community for an acute episode of illness. I am gathering data by conducting informal interviews with nurses - nursing officers, ward sisters, staff nurses, and enrolled nurses - in general medical and surgical wards in a hospital in Edinburgh. Very soon I shall interview a group of patients of the appropriate age to hear what their views are on the subject. Unfortunately, the analysis of these data is at an early stage, and though I will use them, it will be in a tentative way.

3 Are There Ethical Issues?

As in most relatively stable societies, we have a long heritage of law and customs which are the outcome and demonstration of our commonly held moral views. However, these views have and, to a greater or lesser extent, are being challenged by social change. I think it behooves nurses to examine these, both the long-held assumptions and the changing mores, and come to decisions about how they are going to behave as people and as nurses. From our census and from Registrars' information [2, 5], it is clear that there are considerable changes. These include changed fertility patterns, increasing socioeconomic and geographical mobility, rising divorce rate, increasing numbers of women in employment, and increased longevity. Traditionally, it has been the family that has looked after its own elderly members. But increasing numbers of elderly people, particularly of old ladies, many of whom never married (a legacy of two world wars), as well as "retired" daughters looking after aged mothers, make for a need to look again at how we do look after the elderly and how we ought to provide care. Surely there are inherent problems which require ethical decisions.

4 How Do We Think About Ethical Issues?

Within the compass of this short paper I cannot give a detailed exposition of the various theories that have been used to arrive at ethical decisions.

One of the long-held theories that comes from our Judeo-Christian tradition as well as that of the Stoics is that there are positive principles of right and wrong. However, there is a distinction to be made between moral rules which are specific and concrete, like the Ten Commandments, and principles that are more general and abstract. Kant's formula of "Act only on the maxim through which you can at the same time will that it should become a universal law" [3], suggests the idea of "universalizability," i. e., in terms of more general and abstract principles the consequences of everyone's acting in a certain way must not be undesirable.

If one accepts that ethical judgments must be made from a universal point of view and one's own interests can't count for more than any other person's, then as Singer [9] has argued:

> ...I have to take account of the interests of all those affected by my decision. This requires me to weigh up all those interests and adopt the course of action most

likely to maximise the interests of those affected. Thus, I must choose the course of action which has the best consequences, on balance, for all affected. This is a form of utilitarianism.

This, then, would seem to show a means of weighing the preferences or desires of other people, but perhaps here we'd want to introduce the concept of rights. By rights I mean more fundamental moral considerations than preferences or desires which can be violated. I have chosen rights because I see them as being responded to by responsibilities. The consideration of these I have found as a way of raising the ethical issues. Though I will suggest three pairs of what I've chosen to call rights and responsibilities, I make no claim to them being comprehensive or even most important. They are merely interesting.

5 Rights and Responsibilities

5.1 Rights and Responsibilities of the State

Firstly, I would suggest the state has a right to use resources which is responded to by the responsibility to provide services.

What I mean is that I believe that the state has a right to make use of the skill, energy, time, and money that is inherent in its people and land. When thinking about the National Health Service, I contend that the state has a right to use the skill, energy, and time of the doctors and nurses as well as others to operate the system. Clearly, this right can be violated by doctors and nurses or others deciding to withhold their labor or prevent others from giving theirs, or doctors and nurses giving labor only to the private sector. However, if the state does have this right, it must respond by exhibiting responsibility in the form of providing complete health services for all or as many of the citizens as wish to avail themselves of such a service.

Secondly, I suggest that the state has a right to improve its resources, but that is responded to by accepting the responsibility to employ democratic division of resources. I would defend the right to improve resources by means of allowing doctors to pursue research and techniques in a chosen specialty, for example, the funding of heart transplant units, and thereby extend the frontiers of knowledge and skill. However, that has got to be responded to by the responsibility to listen to the democratic arguments as to how these expensive resources should be divided. How else does one carve up the "national cake" between the cardiologist and the geriatrician? I am no expert in the intricacies of resource allocation, though there are those who are knowledgeable [1].

Thirdly, the state has a right to knowledge about its people and resources which it gains by means of a decennial census and the filling in of what sometimes seem to be interminable forms of one sort or another, but this means that we do know how many of us there are and what sort of procedures are being done and where. The state, in response to that right to knowledge, has a responsibility to use that information in a reasonable manner. There is the inherent need for confidentiality for the individual. However, I believe that such information ought to be used to develop forward planning [8], otherwise it would be possible to go on providing services that were no longer needed just because it had "aye been done."

5.2 Rights and Responsibilities of the Nurse

Firstly, I suggest the nurse has a right to be an individual but this is responded to by a responsibility to see patients as individuals. I think it can be difficult for nurses to maintain their individuality; for one thing they are all in uniform. Certainly, they will confess to hiding behind it, though sometimes they see that es being a great advantage! Too, with the nursing hierarchical structure there is great pressure to be good and fit in to one's appointed role. Nurses are an incredibly acquiescing group of workers, though perhaps they are becoming rather less so. An attempt to accept the responsibility to see patients as individuals is being tried by adopting the "nursing process," but often that seems too mechanistic to be really individual. The retention of the nurse's individuality, with all her past, ought to enhance her imaginative seeing of individual elderly patients, who may, for example, be deaf or have different demands in the degree of formality in modes of address or a different sense of humor.

Secondly, I would contend that a nurse has a right to withhold care but this must be balanced by the responsibility to behave in a professional way. By withholding care, I am not advocating cruelty or negligence but rather the acceptance that each nurse cannot like all patients equally, nor can she accept the total hurt of each patient. If she did she very soon would be of little use to anyone, least of all herself. However, this right must be responded to by accepting the responsibility to care for all patients in her charge. It may mean that though she personally withholds care, she will be committed to finding someone, perhaps like a minister or another nurse or social worker, who can profoundly "hear" the patient.

Thirdly, the nurse has a right to obtain information about patients which is answered by the responsibility to preserve confidentiality and perhaps to withhold information. Certainly, my data reveal that this right nurses totally accept and they also seem to think that they can gather it by whatever means comes to hand, and they have no qualms about checking its validity in the sense that they are quite liable to ask the patient, then relatives, and possibly others to check the story. They see this as being of great importance when dealing with the elderly, for they see the patients as not always being totally honest. However, I'm not sure that they really appreciate that shared information makes one vulnerable to the power of information and old people are specially sensitive to such a threat.

5.3 Rights and Responsibilities of the Patient

Firstly, like nurses, patients have a right to be individuals which must be responded to by the responsibility to cooperate. For elderly people, it is hugely important to remain individuals. It is this that retains their dignity and wholeness as people. However, they have a responsibility to cooperate when they are in a setting of shared space and resources, often a very trying and distressing experience.

Secondly, I think that old people have a right to be dependent but they have a responsibility to be strong. I mean by that that when, by virtue of the aging process, they are tired and frail then their dependence must have no stigma attached to it. This dependence does not necessarily indicate a return to childlike dependence with its inability to make decisions for oneself. But the responsibility to be strong means that they must ask for the services as they want them. They must not be fearful to ask doctors or nurses for information. Nor should they be fearful in demanding to be taken seriously.

In the third place, elderly patients have a right to knowledge about treatment and prognosis as well as diagnosis. The responding responsibility is the proper use of that knowledge. Such elderly patients are vulnerable to the assumption, on the part of nurses, that they are too frail or confused to be burdened with such knowledge. It may well be a demanding process to make sure that patients fully understand the information that they have a right to hold. The responsibility of the proper use of knowledge can be difficult for patients to bear if, for example, it involves acceptance of inabilities or the need to change a way of life or habits.

6 Conclusions

I hope that I have been able to indicate a little of the relationship between what I have called rights and responsibilities. Certainly, I believe that neither are absolute because each one is subject to limitation by other rights and responsibilities due either to the same person or to others. The proper tension among all these rights and responsibilities is often difficult to maintain. How, if the pendulum has swung too far in one direction, that can be effected and affected I'm not sure. But it is this very point that is part of the defense for thinking about ethical issues.

Jenny Joseph has summed this up well in her poem "Warning" [4]:

> When I am an old woman I shall wear purple
> With a red hat which doesn't go, and doesn't suit me,
> And I shall spend my pension on brandy and summer gloves
> And satin sandals, and say we've no money for butter,
> I shall sit down on the pavement when I'm tired
> And gobble up samples in shops and press alarm bells
> And run my stick along the public railings
> And make up for the sobriety of my youth.
> I shall go out in my slippers in the rain
> And pick the flowers in other people's gardens
> And learn to spit.
> You can wear terrible shirts and grow more fat
> And eat three pounds of sausages at a go
> Or only bread and pickles for a week
> And hoard pens and pencils and beermats and things in boxes.
> But now we must have clothes that keep us dry
> And pay our rent and not swear in the street
> And set a good example for the children.

> We will have friends to dinner and read the papers.
> But maybe I ought to practice a little now?
> So people who know me are not too shocked and surprised
> When suddenly I am old and start to wear purple.

I would commend her question, "But maybe I ought to practice a little now?"

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Feeding Problems

K. Asplund and A. Norberg

In this paper, we wish to present a hypothesis about the care workers reactions to the feeding problems of the old, demented patient in the terminal phase of life.

The hypothesis is formulated on the basis of taped group discussions with care workers in four long-term care wards over a 2-year, period, interviews with experts, interviews with 200 nurses aides and enrolled nurses in 22 nursing homes, and observations in long-term care wards over a 3-year period.

Our hypothesis is that the situation for the care workers can be interpreted as a double bind. The care workers feel conflicting demands. On one hand, *one must keep the patient alive,* or at least *one must not shorten the patient's life.* In this phase, spoon-feeding cannot keep the patient alive. He often does not understand how to eat or want to eat. He sometimes is not able to eat. Intravenous infusions cannot keep the patient alive for more than a few weeks. The veins are brittle. By subcutaneous infusions the patient cannot be kept alive. He will starve to death. Nasogastric tube-feeding is the most effective means of keeping the patient alive.

On the other hand, *one must not cause the patient pointless suffering.* The patient is hurt when he is spoon-fed. He shows panic. He swallows the wrong way. But the patient is hurt when he is fed by infusions. This patient has been fed by infusions for a month. What was the meaning of this last month from the patient's point of view? The patient is hurt as well when he is fed by tube. He is bent like a fetus and has no mental contact with the care workers. It is hard to avoid decubital ulcers and gangrene. If you do not like to feed the patient by spoon, infusion, or tube then you can let him die from water deficiency. Does the patient then suffer from thirst?

If one must keep the patient alive and not cause the patient pointless suffering, still *one must not force the patient.* Care workers feel that the last spoon-feeding is forced feeding. The nurse has to open the patient's mouth and force him to swallow. The patient may try to defend himself against the infusion or the tube. He removes it. The nurse may have to bind the patient's hands. The nurse feels she forces the patient. In this situation the care workers feel that whatever they do, they do the wrong thing. It is wrong to use forced spoon-feeding. It is wrong to use infusions and tubes. It is wrong to let the patient die from lack of water. If everything you are doing is wrong, you need to talk it over with your co-workers, but sometimes this is forbidden.

In addition to the three previously mentioned conflicting demands, *one must not meta-communicate.* One must not talk about death, suffering, and force. Sometimes one must not even think about it. The care workers behave as if they were unaware of the problem. But their anxiety is easily provoked. If whatever you are doing is wrong and you are not allowed to talk about it then a normal reaction is to escape. You avoid the ward and if this is not possible you avoid the patient.

But sometimes *it is not possible to escape.* When cleaning the patient, the nurse's aide has to see the patient, smell him, listen to him, touch him. The physician, for example, may have to make a decision about the feeding situation.

These persons who feel conflicting demands, cannot meta-communicate, and cannot escape are in a double-bind situation.

Now I wish to put forward two questions:

1. What are the consequences of the double-bind situation for the care of the patient?
2. How can the double bind be resolved?

When everything you are doing is wrong, you feel guilty. You defend yourself against guilt by using the defense mechanisms of the ego. There are many defense mechanisms and combinations of defense mechanisms.

Distancing is probably the first consequence. The nurse says to herself, "This is not Mrs. Smith whom I have nursed for years and whom I like very much. This is only a demented patient. She does not understand and feel." At worst the nurse treats the patient like a thing.

Another consequence may be *demands for orders* by use of pathological games. The real goal is to get rid of the guilt. "Tell me what I have to do, so I can blame you!"

How can the double bind be resolved? You can help the care workers to escape. Some care workers in long-term care should not be there. We need mature care workers in the care of old demented patients. You can facilitate meta-communication among care workers, e.g., arrange group discussions. By discussing, the care workers can verbalize the conflicting demands. The main point is that the conflict must be solved. There are two main groups of problems here:

1. The level of facts
2. At the level of values.

Does the patient who dies from lack of water suffer from thirst?

In that case how can his suffering best be mitigated: by enema, by intravenous or subcutaneous infusions, by intensive mouth care, by morphine given when necessary?

What is more valuable: a shorter life with minimum suffering or a longer life with more suffering?

Who should make the choice for the patient?

In one of our research projects we have asked the question: Can some problems be solved by using bottle-feeding of the old, demented patient in the terminal phase?

Our argument goes like this:

- The nipple does not hurt the patient as much as a spoon or an infusion or tube.
- You cannot force the patient to eat by using a nipple. If the hole is of the right size the patient has to suck in order to get food.
- The patient swallows best when sucking.

Then the patient can eat until he loses his sucking and swallowing reflexes Then he dies. But he dies because he cannot eat any longer not due to a decision by the care workers.

Here we have not only a problem of facts but also a problem of values. Some nurses in Sweden feel it is wrong to treat an old patient like a baby. It is unnatural and disgusting.

The task for the nurses in this feeding situation is a paradoxical one.

She has to simultaneously accept the childlike behavior of the patient (fetal and neonatal reflexes reappear) and remember that the patient is old. He has life experiences.

In addition, the nurse has to accept that the patient is dying and at the same time is living. He even has the right to have sexual experiences. Some patients show pleasure when sucking. It can be interpreted as oral sexuality. This conflict between life (sexuality) and death is the main human conflict. The feeding of these old, demented patients is not only a matter of food but also a matter of love.

IV. Nursing: Cultural and Religious Aspects

Introduction

Since attitudes toward health and disease are socioculturally determined, nursing care must take into account the beliefs and practice system of the individual. This includes ritual as well as political and social issues. The patient must be viewed in his specific cultural context. In addition, since the individual does not live in a vacuum, this cultural specificity must also be taken into account with the cultural diversity of the society as well as the personality and culture of the nurse.

Religion also plays an important role - both by its presence (implicit and explicit) in the individual and by its absence. Visiting the sick and ministering to the sick is viewed by some religions as a religious virtue and duty. In the Jewish view, this is considered part and parcel of medical ethics, by its encouragement. Care societies work as a group and individually in order to provide for the religious and material needs of the patient.

The nurse, in addition to her professional duties, also serves as a parent-surrogate. This may mean treating the physical, emotional, and spiritual needs of the patient. The professional dedication of the nurse to her duty has been compared by some to the religious devotion of the believing.

Christian philosophy, in its transcendent as well as its radical sense, also stresses the ethical aspect of care and treatment. Norms and values (parallel to principles and action, in some professional circles) are essential to nursing treatment philosophy. One cannot over- or underemphasize the ethical aspect.

This section contains papers from Israel, Italy, and South Africa that explore the areas of culture and religion as they relate to nursing care.

The Economics of Caring

K. M. Boyd

Although I am not an economist, I would like to try to explain why I think that economics is too important a subject to be left to economists. Economics is not just a science but also the practical art of political and household economy, which involves making moral judgments. Nurses, I suggest, are and should be practitioners of this art. It ought also to be possible for nurses to discuss these judgments rationally, in an open forum, and sympathetically with those affected by them. The economics of caring, sounds like a contradiction in terms but actually is not, because genuine caring implies wanting to see the cared-for good realized and because we commonly care for the good of more than one person or object. Dispensing with the preliminaries let me turn straight away to some of the moral questions raised for nursing by the economics of caring. Let me do this by talking first about problems which arise at what economists call the macroeconomic level, those which used to be called questions of political economy, and second about problems at the microeconomic level, those of what used to be called household economy.

At the macroeconomic level, or in terms with which political economy is concerned, a major feature of the economics of health care has been the steep rise in expenditure on health services in developed countries since the 1950s. A typical Western country which "had spent 2½ per cent of its national product on health in 1950, was spending 6 per cent of a much larger GNP in 1969" [2, p 18]. In Britain (which has spent proportionately less on health services than the average for Western countries), total expenditure on the National Health Service (NHS) between 1949 and 1979 "more than doubled and the volume of resources devoted to the NHS ... increased in every year except 1952." Total NHS expenditure, moreover, grew "faster than the rest of the economy in almost every year since 1954, rising from 3.4% of the gross domestic product (GDP) in 1954 to 5.6% in 1977 [3, p 332].

These rising costs, In Britain at least, reflected public and professional optimism that equal access for all to modern medical treatment and prevention would improve general levels of health and possibly in time even reduce the need for health services. In terms of many previously fatal or disabling conditions, this optimism seems in part to have been justified. But the multifactoral etiology of many remaining health problems and the growing health needs of an increasingly elderly population have raised doubts about the returns which can be expected from continuing to spend an increasing proportion of natural resources on conventional health services and, in particular, on acute hospital medicine. At the same time, the potential benefits of increased expenditure on care of the elderly, the mentally ill, the mentally and physically handicapped, and on preventive medicine and health education have been difficult to demonstrate in the dramatic "live-saving" terms which mobilize public opinion and the political will to spend. A further feature which has blunted earlier optimism, of course, is a growing realization of the role of demand as well as need in the health care equation. Even with continued optimism about the benefits of increased investment in medical excellence, however, growth on the scale experienced since the 1950s could not have continued without, on the one hand, further growth in the national economy and, on the other, some willingness to sacrifice other purposes to which public (or, for that matter, private) expenditure might have been applied. In fact, the absence of significant economic growth, in Britain at least, has now led to political decisions which have slowed down the rate of growth in health service expenditure. This development has made even more acute the problem of the proportion of the national wealth which should be spent on health services, as opposed to other social purposes. It has also made more difficult problems about the proportions which should be spent, within the health allocation, on different categories of need or demand, that is, on different patient groups or different specialties or services, on the hospital as opposed to the community, on different geographical areas with histories of unequal provision, or on the particular needs of different socioeconomic classes, including the most deprived.

The problems of proportional expenditure, both between health services and other public services and between different categories of need or demand within the health service allocation, have a significant feature in common. It is difficult, and maybe impossible, not only to quantify these needs and demands entirely satisfactorily for predictive purposes but also to isolate any single need or demand from its interaction with the others. In Britain, for example, there is a growing impression that unemployment may be adding to the burden of national ill health [4] and mortality [5]. Although evidence for this is as yet difficult to establish scientifically, it raises the question of whether money would not be better spent on attempts to create new employment than on health services for the casualties of unemployment. Within the health allocation, too, the difficulty of quantifying and isolating the needs and demands of different categories can be seen. A political decision to spend more on, for example, the handicapped, at the expense of acute hospital and maternity services might lead to poorer early detection and prevention of handicap and thus to an even greater proportion of handicapped people requiring care. Or again, current emphasis on prevention and health education, if successful, could create not only the benefits of longevity for individuals but also, eventually, much heavier demands on geriatric services.

Questions of this kind raise formidable problems for all who are concerned to see an equitable distribution of resources among different classes of patients and of the population and among the different interest groups within health services themselves. At present, despite many attempts by economists, no satisfactory scientific method of setting priorities exists. A recent Scottish Government Working Party on Priorities, in reaching this conclusion after an exhaustive study of possible methods, commented that "a pragmatic approach, in which value judgements would necessarily play a particularly large role, was best in present circumstances" [6]. This conclusion, in emphasizing value judgments, underlines the importance of moral judgment in the macroeconomics or political economy of caring. The pragmatic approach this Scottish Working Party adopted (in giving priority to those suffering from multiple deprivation as well as to groups selected for demographic or epidemiological reasons) expressed a commitment to the particular moral value of greater equity. As it admitted, however, its approach *was* a pragmatic one, and in the absence of overt public consensus about the values or principles on which allocation should be based, the question of *whose* value judgments were to count, and for how much, thus became particularly important. In the macroeconomics or political economy of caring generally, indeed, the problem of quantifying and isolating the needs and demands of different groups, and the inherent difficulty of relating these needs and demands to moral values, let alone the problem of establishing priority among moral values, makes the question of rules of procedure of the greatest significance. In parliamentary democracies, there is a strong presumption that the only ultimately satisfactory procedural rules are those of political government. This view is not shared by those systems of government which, in principle at least, value equality above liberty. Nor is it obvious even in parliamentary democracies how to strike a fair balance in matters of health care priorities between the rule of politics and the role of professional advice. Quite possibly, of course, there are no entirely satisfactory procedural rules. Calabresi and Bobbitt, for example, have carefully analyzed the full range of resource allocation methods - the market, politics, lotteries, and a customary or evolutionary approach - together with many refinements of these methods. Having done this, they conclude that *all* methods of allocating scarce resources support some moral principles or values only at the cost of violating others and that the cost of an open society is the painful tension this knowledge brings. Thus an open society, if it is also to be a moral society, they argue, "must depend on moral conflict as the basis for determining morality" [7].

This moral conflict at the heart of the macroeconomics or political economy of caring is clearly of importance to nursing ethics, not least because wage and salary costs normally represent the largest item of health service expenditure and because in most developed countries nurses are the largest single group of health care personnel. In Britain, for example, wage and salary costs amounted to about 70% of NHS expenditure [2, p 19]. The total NHS work force is now over 1 million, out of a total UK population of 55 million [3, p 177]. It has been estimated that if manpower trends during the 1960s had continued, half the population would have been employed in hospitals in the early 21st century [8]. In 1975 the typical Western proportions of health service personnel groups were 15 doctors, 27 nurses, 4 dentists, 5 pharmacists, and about 100 supporting staff for every 10000 population [2, p 19]. In 1977, nursing and midwifery staff represented 43% of British National Health Service employees. The next largest group was ancillary staff and others at 21.9%, followed by administrative and clerical staff at 12.3%, doctors at 6.7%, and professional and technical staff at 6.5% [3, p 178]. As members of this large professional group, as in many cases health care planners and managers, and as citizens, nurses are confronted with these macroeconomic moral conflicts. In coming to terms with this, nurses may well also come to agree with Calabresi and Bobbitt that, while tragic choices inavoidably "need to be made," are not the easier for the understanding of them [7]. A no less difficult conclusion may well be reached in relation to the microeconomics of caring, that area which is closer to household than political economy. Nurses are involved in this area also as professionals, as planners or managers, and as citizens. However, the moral issues involved here can perhaps be better illustrated by seeing nurses, on the one hand, as major users of resources in day-to-day health care and, on the other, as advocates of the rights and interests of individual patients. A great variety of examples could be given of the moral problems which arise for nurses in the microeconomics of caring either in the ward or in the community, but let us just discuss one apparently trivial incident.

A nurse is in charge of an acute surgical ward, at one end of which sits an old lady recovering from skin-graft surgery after burning her leg in front of her fire. The surgeon has said that she can now either return home or go to the convalescent hospital. He has also reminded the nurse in charge that tomorrow is the ward's waiting day and he will need the bed. The old lady herself has expressed a strong desire to go home. But the convalescent home is full, the overstretched ambulance service is fully committed at another hospital, and the part-time social worker (also unobtainable today) has left a message to say that the old lady's only relative (a daughter living at a distance) cannot get to her mother's isolated cottage to look after her for another week. Home help is not available because of government economies, and the district nurse is off sick with inadequate cover. The nurse in charge of the ward is not convinced that the old lady will be able to look after herself on her own. While ambulant, she is still very slow, and during her stay in hospital she has seemed at times confused. Yet on discussing her discharge with her, the old lady is adamant that she wants to go home: She has electricity at home and tins of food in her larder. This notwithstanding, she is actually very poor and has not enough money with her even to pay the bus fare to the road-end near her home, which is some considerable distance from the hospital. The nurse in charge has considered the possibility of ordering a taxi to take the old lady home at the health service's expense and has remembered the recent hospital circular warning against the use of taxis except in cases of dire emergency.

In this example of the microeconomics of caring, the nurse in charge has to count a variety of costs. First, as a major user of resources (as well as a manager and a professional) she has to count the cost, on the one hand, of using the excellent facilities of an acute surgical ward for what are convalescent or even social purposes and, on the other, of using expensive transport at the public expense. The cost involved here is not just to some impersonal public purse. An important aspect of the microeconomics of caring, particularly at a time of no growth in provision, is the fact that resources spent at one place are eventually not available at another. At the end of the line, in other words, are other patients whose needs, whose health, and even, in some cases, whose life may be threatened by the nurses's action. As a user of resources, it is easier perhaps for the nurse to see this in terms of the last-minute emergency patient who may not get a bed in her ward tomorrow. But sufficient taxi fares may well add up to a decision, next year, to postpone the replacement of some important piece of equipment in her ward or elsewhere.

The nurse, however, is also the patient's advocate, and she also has the problem of counting the cost of what is best for the old lady. Part of this problem can be seen as a question of what is in the old lady's interests, and the nurse, as we have seen, has serious doubts about sending her home to a situation in which she may not be able to look after herself or may injure herself again. These considerations, moreover, may well be mixed with counting the cost to the hospital or the profession should any such injury or death become public knowledge. But the question of what is best for the old lady, of what is for her good, is not simply a matter of calculations about what the nurse sees as her interests. As an advocate of her patient, as someone who cares for her good, the nurse must also consider the patient's rights. Generally speaking, rights include *positive* rights (rights to have something done *for* one) and *negative* rights (the right not to have what one does not want done to one).

Generally again, positive rights (beyond a basic, albeit variable, minimum) are rights which can only be delivered if the resources to do this are available, and because of this, positive rights are not always easy to defend. In the old lady's case, for example, it would be difficult to justify that she had a right to the taxi fare. On the other hand, *negative* rights, including the right not to be interfered with in the exercise of one's personal freedom when this does not harm other people, cannot easily be denied without serious *moral* cost. In the old lady's case, therefore, the nurse, whose knowledge of the hospital's ways puts her in a stronger position than the old lady, may be morally at fault if she deceives the old lady by saying that there is categorically no way in which she can go home. What I said earlier about the need for practical economists to discuss the reasons for moral judgments rationally in an open forum, and sympathetically with those affected by them, is clearly relevant here.

In the microeconomics of caring, then, the nurse's different roles raise a variety of conflicting moral considerations. When we discuss cases of this kind in our ethics seminars, students commonly suggest a great variety of pragmatic "ways round" the moral dilemmas involved, often at the expense of discussing the fundamental moral issues. The ingenuity they show in doing so is something to be grateful for, since in practice it will often be needed. But in practice, too, there are also times in the microeconomics of caring when ingenuity - either at that time or at the end of the line - is not enough and when tragic choices, which offend against some moral value which is important to us, have to be made. In these circumstances, the household economy of caring demands acutely, of fallible individuals, what the political economy of caring demands acutely, of fallible individuals, what the political economy of caring demands more chronically of societies, namely, the moral courage to act decisively in the face of irreducible tensions and unrecoverable tragedy and also, one might add, the moral courage to live with such decisions.

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Illness: A Time of Stress Involving the Relationship Between the Individual Personality and Cultural Backround

M. B. Agostino and J. Sansoni

This topic may be considered under several, apparently unrelated, aspects. Nursing is not and should not simply be care of the patient without regard to the *person.* The concerned relationship between the individual and his/her illness is important for the nurse both with respect to the actual illness (a problem which is obviously the same for doctors and nurses alike, according to their particular responsibilities; this becomes an individual, ethical problem) and the condition of the patient in relation to the treatment he receives. In other words, if it is true that no illness can be completely foreign to a patient's culture (in its anthropological sense, which will subsequently be discussed), it is also evident that the "period" of illness is characterized by a conflict which is culturally determined. The problem of the relationship between personality and culture, much discussed by anthropologists, is still one of the most delicate theoretical topics, both scientifically and practically. It is not possible here to explain the theory of personality and culture relationship, but it must be noted that independent of different opinions among anthropologists, this relationship is very strong. However, at this point we might briefly explain what we mean by "culture." The relationship does not signify "complete conditioning," as for example, the theory of "the basic personality" would intend. Relationship means a "dynamic" tension, in conflict as in function, task, and service. By culture we mean the total environment which the individual learns, naturally and unconsciously, to become a person, by way of language, eating habits, customs, norms, values, in history of the group to which he belongs. Consequently, in moments of great stress, the individual naturally tends to hold on to familiar habits which are natural to him (natural obviously means "cultural," as the nature of *homo sapiens* is his culture) and to values which will help him gain strength and security and defend her his identity.

It is therefore evident that illness itself, and all that it involves in hospital, creates confusion in daily life and exposes the personality of the patient to risks. The lonelier the patient (illness cannot be shared with anyone), the more is demanded of on whom his well-being and recovery depend.

This is only a short introduction to the problem we intend to discuss - the patient's cultural condition. Cultural condition means, above all, to "live" at a specific time in a specific place it varies from culture to culture and shapes the environment in which daily activities take place.

In our Western culture, we are all used to observing certain timetables, which not only regulate daily life but also vacations, religious holidays, and so on. The worry about time, which for us is so deeply rooted, is not so relevant in other societies. Consequently, the timetable in a hospital, with regard to cleaning, sleeping, eating, working, etc., may be very different to what some patients are used to. For example, time of meals and quantity of food, time and names of cleaning both individuals and the hospital environment, visiting time (which precisely shows the "diversity" of the patient's environment) - in Italy people never visit one another in the early afternoon, which is almost always the visiting time in hospitals. Hospitals are not run in accordance with the outside environment, but according to their own needs. These remarks can also apply to space: territoriality with respect to the feeling of one's own body, one's own physical existence and ego, the concrete and psychological space between one individual and another, one's own uniqueness. These needs, which are universal, vary among human beings, according to culture. Thus some individuals have a different "measure" of necessary space, of the distance between themselves and others, depending on their cultural habits.

This distance is so "instinctive" that even though no one has ever measured it in meters or centimeters, we all generally assume the "right" distance when talking to someone and we will immediately notice if someone is standing too near or too far away from us while talking. If one steps too close without knowing the person, this is interpreted as a signal of "bad manners" or a "sexual" message, according to what is considered the right distance. Some anthropologists consider that the distance is dictated by the security needs of one's own territoriality, which is the same as in animals. It is not possible in this paper to make an analysis of the concept of territoriality; it is, however, important to realize that the need exists and that it differs from one culture to another. Translated into real terms, this means that the patient needs his own "personal space," sufficient not only for his basic needs but also for those unexpressed "limits" that are internalized and dependent on his cultural habits.

The desire not to be allocated a central bed should be satisfied both if there are free beds in the ward and when distributing hospital space. Obviously, these observations concern all the personal articles of the patient, clothing, furnishings, color of the walls and wards: It is difficult to imagine a complete change, but these should nonetheless be considered. The hospital, as generally organized, is one of the "total institutions" (as defined by the anthropologist Goffman, referring to barracks, prisons, monasteries, and psychiatric hospitals) which in its organization is detached from life outside; it functions only for itself and consequently everything is homogenous - patients, beds, walls - equal objects, alike in color and shape.

This is one of the reasons why patients live the period in hospitals and clinics as a particular time of "regression" to childhood, a time, in fact, of life that society tries to homogenize (children live, more than anyone else, in similar conditions with regard to their "body", while society indicates how to bring up children, when they should eat and sleep, what "articles," from toys to pots, are not suitable unless they are the same as the others). This form of childlike regression, encouraged by society, urges the patient to give up, to leave himself in the hands of those nursing or assisting him (probably depending on sex, as women are, in fact, much more used to taking care of themselves than are men). This is a form, of "abnormal" behavior, which leads to an aggressive mood that is more pronounced toward nurses than to doctors.

This is an important point: The nurse's image, both because she is, to the patient, in a subordinate position compared with the doctor, and because she is the one who actually "manipulates" the body of the patient, thus becomes rather ambiguous and interpreted both as a "vice-mother" (with all that this connotes) for adults in a weak position, and as not completely reliable in terms of technical competence as regards care. In other words, a "mother" is not a "doctor," although she was considered so during childhood. This results in a trust-mistrust which, according to a patient's illness and psychological behavior, will lead him sometimes to ask too much of the nurse on an emotional level and too little on a technical level. The nurse's task becomes, in this way, quite difficult because in a society where the doctor tends to become a purely technical figure, the technical specialization is overestimated and this means that he attains a charismatic and untouchable image. The nurse is paying the consequences; in fact, the more "emotional" assistance is required from her, the less her technical competence is considered.

It is in this perspective that we mentioned the real manipulation of the body of the patient as one of the "neuralgic" points in the complex relationship; patient-nurse-doctor-illness-culture. This relationship, in fact, "passes" through the body and the way the body is interpreted in very single culture. The soul-body or spirit-body dualism is difficult to extinguish, even though we try to today. It has characterized our history, meant that "serving the body" of others is not mortifying at all, at least in it's most severe aspects, either for the sick person or for the nurse. This is because only the body is nursed and not the "total person" or ego of the sick person. On the other hand, until quite recently, nursing was a voluntary choice, almost always performed as a service to God through the sick (e.g., nearly all religious congregations, especially female, started with this objective). Today, on the other hand, all treatment of the body is interpreted in a much more humiliating way both for those performing and those receiving the treatment. The body is considered the "whole person," totally part of one's ego, and therefore everything it involves concerns the person in his uniqueness, absoluteness, and totality.

The concepts of "decency" and "shame" exist, although the contrary has just been in ferred; what has probably changed is the meaning and motivation of decency. It has lost its typical Catholic characteristics, concerning the sinfulness of the body and has become "self-defense" in relation to others. Serving the body of others, therefore, has become one of the "lowest" tasks because it means to serve another *person* totally. Even though it is not possible to describe completely in a few words this transformation, one can, we suppose, without hesitation establish that the "professionalization" of almost all tasks serving basic needs of the body depends on this transformation of the meaning of "serving." The shortage of nurses is correlated, not infrequently with a shortage of all those who serve the body, including maids, servants, cooks, cleaners, and even housewives.

One tries with professionalism (which in this case does not correlate with technical competency and is very important) to "impersonalize" the service, to make it as "neutral and distant" as possible, both for those serving and those receiving (cleaning companies for example, where personal contact no longer exists). Therefore the nurse's difficulty in relation to the patient's way of interpreting the significance of the body is in transformation, more or less in all cultures but especially in the Western world. The manipulation of the body to meet its basic requirements is committed to the nurse and this produces several reactions that are almost impossible to control. Due to the complexity of the question, we will just consider one of the most important aspects: the difference between the sexes in perceiving one's own body -

and the particular illness that has stricken it due to the relationship between personality and culture; this involves the admission of males into the nursing profession. This is a important part of the dramatic relationship that patients live with cultural norms, with their identification as a person, with that transformation of the relationship with the body that one would always like to respect, even in the most difficult situations, but rarely succeeds in doing so.

The mortification with which one perceives the necessity of letting others assist one's own body is even more serious and quite difficult to solve in a short time (except if you accept, as it seems to me, the authoritarian organization of hospitals as a model). Regard, for example, male nurses in wards with only women, especially in gynecology. The violence that women have to accept as patients would not only not be accepted when living a normal, healthy life (such as nudity, touching, etc.) but would even be considered badly by society, is totally part of the personality-culture relationship previously mentioned. How can we expect a patient who is already in a weak position to submit herself to something that would not even be considered in daily life? Therefore a double violence exists due to the double contradiction with respect to cultural and social values.

If it is so necessary for men to start to deal with basic needs, they can and should do it, at least for now, in male wards, even relieving female nurses from the task that they have always done: nursing men. This would probably be viewed in a positive way by male patients, who have until now often regressed to childish behavior just because of the presence of female nursing personnel that they identified as a maternal figure.

Besides this one cannot remove (not by having male nurses nor even mentally, as this would be hypocritical and impossible) the implied sexual relationship between men and women; neutrality, on the other hand, would lead to the opposite of what is meant by considering the patient and his body as an object.

But this can't take place because sexuality has its origin in communicating messages through the body and besides men are still (and will be for a long time, in my opinion) in the habit of considering the woman's body in a very basic and rough manner.

It might be superfluous to observe that gynecologists and doctors are generally men! This is a historical reality and not a reality of values. Only men could study, only men could have a social position, only men had the power. That doctors and gynecologists are men is not only a commonplace reality, when trying to indicate values for the future, but it is also the result of women's historical and psychological condition, that in almost all cultures, including the Western world, has until now been "taboo" especially in moments of reproductive activity (menstruation, pregnancy, delivery, and puerperium) which made them unfit for social activities.

Of course one can't draw every possible conclusion in this occasion as there would be several topics to discuss, many of which are interesting ideas for further research and have often, up to now, been left unsolved.

I would like though to mention at least some of them, which might be useful to us. For example, I think that it is very important to consider the different ways in which some illnesses are interpreted by society, and the different ways that patients experience their illnesses. It is sufficient to mention, for example, the various ways in which psychiatric symptoms are considered by different cultures: schizophrenia, psychosis, hallucinations, all of which are doubtlessly thought of as various kinds of mental illness by us, in other cultures may be considered as symptoms of a religious vocation. For example the witch doctor must assume a feminine appearance to be able to experience his visions and communicate with the transcendent. Obviously passive homosexuality acts as a substitute for femininity, so much so that the witch doctor will dress in female clothes and become the wife of the head of the group. These are cases which would doubtlessly be diagnosed as pathologic, with perhaps the exception of homosexuality, by the Western culture.

Another case of illness experienced in a negative form by society is that of epilepsy which, in Italy for example, has been until now regarded as "shameful," especially for the female sex, so much that it was kept hidden even from the doctor in certain parts of Italy, because such women had difficulty in finding a husband.

It is necessary to at least mention the problem of pain and the different ways in which it is experienced and considered from one culture to another. This is of course too complex to be dealt with in a paper which is already too long. However, the way one suffers is strongly influenced by one's own culture (for example, the way in which the "value" of physical suffering has been inculcated by Catholicism in order to "ascend").

Suffering is also shown differently according to sex, in as much as the male, in the "strong" role which is forced upon him by society, must control his suffering even when he is in great pain, whilst women on the other hand, can show their pain more openly.

However, where birth is concerned, women must also show themselves to be strong in the maternal role that they are expected to accept lovingly, and they are often chastised, even by the medical staff, if they complain in a way that then consider excessive. All this serves to show, once again, how cultural and social conditions can influence the patient's behavior, and it gives rise to another problem: whether or not the external behavior demanded by society can actually cause pain (within certain limits), more or less intensely according to the external manifestations.

Lastly I want to mention the anguish, the anxiety, and the fear experienced by dying patients or those with very severe conditions.

Death is experienced differently according to cultural convictions, one of which being religion. But even religious convictions play a different role than usual, this being the moment when they should be of real help, when they can be shown as being weak or doubtful. This is almost always the case, whatever the religious convictions of the patient may be.

Death is "seen" differently by someone on the brink of death and therefore the state of almost complete isolation and solitude in which he finds himself may perhaps be aggravated by an environment or atmosphere which is profoundly "believing" in life after death. This happens because the person cannot fully express his fear, anguish, and uncertainty about the "life beyond" to those who surround him because, to console they speak to him in terms of "faith." On the other hand, this same solitude is felt equally by those who do not believe in an afterlife and whose fears are consoled with false hopes of cure. It is clear that a patient in grave condition is nearly always aware of the state he is in, even if he passes constantly from hope to fear; something which is not perhaps completely verifiable because a moribund person is one who "lives" his death alone and is unable or incapable of expressing it.

I believe that this "separateness" of the moribund person, which is often seen as something positive by other cultures, who may leave him alone or even kill him before death arrives "naturally," so that it seems to them that he isn't really dead.

Lastly it's sufficient to think of the *avoidance* of the moribund person and later of his corpse, which is considered as "contaminating" by almost all cultures. This means that, whilst protecting the living, in reality the patient is left extremely isolated at the time of his death. Summarizing, death cannot be "experienced" and therefore cannot be communicated.

Finally, faced with such a vast range of problems arising from the complex relationships among doctor-nurse-patient-hospital-culture, the program of education for the nursing profession cannot but include a thorough knowledge of cultural aspects. Furthermore, for each single topic, the nurse must ask herself if what she is doing fulfills all the needs of the persona of the patient, as a member of a particular culture with it's own values, meanings, habits, etc.

What we have tried to emphasize in our I paper is that nurses in their professional role should, first of all, be aware of the basic physical and psychological needs of patients. Wherever nurses may work or whatever their career may result in, it's essential to our profession to care for the patient's body in all it's physical expressions as well as in it's personal significance.

Religion

Nursing in Jewish Medical Ethics: Visiting the Sick

S. Kottek

1 Introduction

To nurse (from the Latin) means etymologically to nurture, to nourish. Therefore, a nurse was first of all a woman who suckled and, secondarily, one who took care of an infant not her own. It appears thus that the woman who cares for or cures the sick was originally meant as one who nourishes. In the same manner, the hospital was first a hospice (from the Latin *hospitium*), a shelter, or hostel, i.e., an inn for strangers [2, 3]. Modern Hebrew has adopted the noun *aḥoth* (sister) with the Christian background of religious orders devoted to the poor and the sick. The more accurate term *meṭapeleth* has been derived to designate dry nurses or domestic servants.

This philological introduction shows us that there are apparently no older roots to the nursing profession in Jewish antiquity and the Middle Ages. We may then ask ourselves what happened to the poor sick people, especially those who had no family to care for them. As a matter of fact, the religious duty of visiting the sick *(bikkur holim)* was quite efficient in replacing the absent nurses. Close or remote relatives, friends, neighbors, in fact, anyone who happened to hear of an ill stranger in town, assumed the office of a nurse and nobody was left in want.

We have dealt elsewhere [2] with the similar reasons why Jewish hospitals only appeared towards the end of the eighteenth century, although there were plain shelters for the strangers and the sick throughout the Middle Ages and perhaps even in Talmudic times. Strong family ties, strict rules for hospitality, and charities were the main reasons for the absence of public health care. Interestingly enough, modern trends have stressed the noxious effects of hospitalization and developed the systems of home care and of ambulatory treatment, thus leaving the patient as much as possible in his own environment. Once again, we are in the presence of an old-new idea! Let us now delineate a brief outlook on legalistic and ethical rules related to the visiting of the sick.

2 The Duty of Visiting the Sick

To bring home guests and to visit the sick are two religious duties that have no limits: the more, the better! (Babyl. Talmud Shabbat, 127 a). It is of course not by mere chance that those two religious duties are cited together (in a list of ten foremost rules). They may be considered as complementary, because together with the obligation to give money for the needy, they solve the problem of public health care.

The Lord Himself showed the way to the patriarch Abraham when He sent him three angels to visit him after he had circumcised himself (Genesis 18: 1), a lesson that should not be overlooked (Babyl. Talmud Sota, 14a).

In Talmudic times, renowned rabbis used to fulfill this religious duty. Rabbi Aqiba (second century) paid a visit to one of his disciples during his illness and had his room thoroughly cleaned and thus the patient recovered. The young scholar exclaimed: Rabbi, you revived me! Rabbi Aqiba accordingly taught: he who refrains from visiting the sick is close to committing bloodshed! (Babyl. Talmud Nedarim, 40a).

But it is not always easy or rewarding to approach a sick person. Let us cite the case of Rabbi Simeon b. Yoḥai who once visited a man who was lying with an intestinal disease and was reviling the Lord. Rabbi Simeon exlaimed: You worthless man, why do you blaspheme, when you should be asking for mercy! The man answered: I pray the Lord should take my disease off and lay it upon you! The Rabbi answered: This is exactly what I deserve for having neglected the study of the law in order to occupy myself with vanities. (Aboth de Rabbi Nathan, 41, 1). This strange story deserves a commentary. Most commentators think that the duty of visiting the sick should not be preferred to study of the law if it may be done by others. To me it seems that this story exemplifies the necessity to address an ailing person with mild words, not harshly, or else visiting the sick turns out to be a vain enterprise. This is beautifully expressed in Psalm 41, verse 7: "If he [the enemy] comes to see [me, lying ill], he speaks vanities, his heart gathers falsehood he goes out and tells it abroad." The enemy here can be seen as he who comes with inimical feelings; he may bring no help to the sick.

This duty appeals to the body, the pecuniary resources, and the soul of the visitor. He is requested to care for the physical and financial needs of the sick and pray for his recovery. It is therefore seen as a total involvement, not a merely formal act.

3 How to Fulfill the Duty

We do not intend to detail all the rules formulated by the sages [1, 5] concerning our topic, but let us cite some of them. Relatives and close friends may enter at once, others should wait 3 days before paying a visit to the sick. The more they go, the better, provided that they do not disturb him. There are several diseases where visits are not welcomed, particularly if speaking is difficult for the patient. Visits should not be paid during the first 3 hours of the day nor during the last 3 hours. Maimonides (Mishne Tora, Hilḥot Evel, *14,* 5) explains that at these hours the patients were being cared for and therefore visits were not welcomed. The visitor should, before leaving the room, pray for the recovery of the patient. The latter should never be left alone and he should be supplied with food in accordance with his disease.

3.1 Psychological Considerations

Psychological considerations are particularly important. The visitor should not be seated higher than the patient; he should face him and tell him invigorating and cheerful tales. The visitor should enter the room with a merry countenance and *one should choose people of cheerful character to attend the sick.* The visitor who sympathizes with the patient takes off 1/60th of his disease (Babyl. Talmud Nedarim, 39b), which probably means that he relieves his anxiety. An interesting remark is that if both the patient and the visitor are of the same age, the visitor takes over this 1/60th of the disease on *himself.* This is evidently meant as a transfer of part of the patient's anxiety to the visitor. If the visitor feels that he brings no relief to the diseased person, he should take leave. In case of a serious disease, one should stay in the anteroom, ask if the patient needs any help, listen to his lament, and pray for mercy on him. We would like to stress the need of *listening to his complaints,* already requested by Nachmanides (thirteen century) [5].

3.2 Organized Sick Care

As a general rule a man may attend a sick woman and a woman a sick man. But in case of an intestinal disease (for instance dysentery), a man can attend another man, but not a woman. But a woman may attend a man even in this case.

Regarding epidemic diseases, there is no duty to visit such dangerous patients and put oneself in real danger. In such cases there are *paid volunteers* who will be in charge of the care of the sick. However, there were different opinions, some of the sages would make no difference between epidemics and usual diseases.

The general duty of giving money for the poor includes providing for the sick. There have been organized societies in Jewish communities since very remote times, even in the Talmudic period and throughout the Middle Ages [4]. Sometimes the so-called *ḥevra kadisha* cared for the sick and the dead as well. In other cases there were special societies for *bikkur ḥolim* (visiting the sick). In the medieval *hekdesh* (shelter) usually attached to the synagogue, the occasional sick strangers were attended by the beadle or his wife (if speaking of women) [4]. But these were mostly emergency cases: we have already stressed the fact that until the end of the eighteen century sick people were usually attended to in private homes.

4 Conclusion

The care of the sick may be considered as part of the duty to care for the poor, the orphan and widow, and the stranger. Sick care is first of all hospitality, and if you cannot take the diseased into your own house, then you are requested to go to his house and help him in any possible way.

The modern Hebrew word for nursing is *Si'ud,* a root that appears no fewer than six times in the Psalms. Again, the meaning of this word is to support, to strengthen, to assist, but also to satiate (cf. Genesis 18: 5).

The best conclusion could be taken from the said Psalms, where, once again, the poor and the sick are treated together:

> Blessed [is] he that considereth the poor ... The Lord will strengthen him upon the bed of languishing: Thou wilt make all his bed in his sickness. [Psalms 41: 1, 3]

The Lord himself will give support and assistance:

> Hold Thou me up
> And I shall be safe. [Psalms 119: 117]

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Ministering to the Sick

Y. A. Shapira

1 Introduction

In the Book of Genesis we read about the creation of man, "And so God created man in His own image - in the image of God created He him." (1: 27)

Man was created by God so that he will represent godliness in this world, and so man does not belong unto himself alone, but to the one who created him. The status of man is explained in the Midrash Rabba Chapter 28: "I created all animals and beasts only for Man and now that he has sinned for what do I need them?" The world and its content are not of any value except if they fulfill human needs. The value of man is measured only in terms of quality and not of quantity. Our wise men have therefore explained in the Talmud (Sanhedrin 37 a) that Adam was created singly in order "to teach us that anyone who destroys a single soul is looked upon as if he had destroyed the whole world. And anyone who keeps alive one single soul is as if he had saved the whole world." Man is a cosmological creature, since each man's influence is felt throughout the universe.

Considering the status of man in the universe, the Torah commanded us in Deuteronomy (4: 9): "Only take heed to thyself and keep thy soul diligently." That means that man is *obligated,* and not just allowed, to take care of his soul. The soul has been given to him only as a loan and he is not the owner of it.

Based on what has been said, Maimonides declared in Hilchot Dayot (Chapter 4, Halacha 1) that it is God's wish that man have a healthy body. If he is sick, he is not able to perceive the greatness of God's ways. Man must therefore keep himself distant from those things that may harm his body and behave in such a way that he stay healthy and strong. Therefore, keeping healthy is a religious obligation, since man was created in order to understand and publicize God and His ways. Man must maintain this physical strength and health. Furthermore, Maimonides states in Hilchot Rotzayach, (Chapter 11, Halacha 4) that "anything which poses a danger to a human being has to be removed and kept distant and one has to be very careful of it. This is a positive commandment of the Torah. But, if he did not remove the obstacle, but rather puts it down where it creates a danger, then he has violated a commandment." Everything that is done in order to keep the body from danger is, in a way, a fulfillment of the wishes of God. Conversely, if something is done, even of a minor nature, to hurt his health, he has sinned against God.

Curing a sickness or arresting its progress by therapy is a holy duty and is considered as if he had saved a whole world. It has, therefore, been accepted as law that saving a life defers all laws of the Torah. All commandments are deferred when they endanger the life of a man. His holy value as a human being is greater than the entire Torah. The Holy One is willing to achieve the fulfillment of his tasks and prefers the existence of man. This has been beautifully expressed by our sages in the Tractate Shabbat (151 b) when they said that for a living being one is entitled to violate the Shabbat, but for a dead King David one may not.

2 The Sickness

If the life of a person is so valued by the Creator, why do we then have illnesses? This is mentioned in our Midrashim (Yalkut, Lech Lecha). "Until our forefather Jacob's time, a man used to sneeze three times and then die suddenly. Then Jacob requested that there be sicknesses, so that man will die in his home and depart from this world quietly, secure in his knowledge that there is a continuation to his life, in that his spirit will be effective in the world even after his death." Illness is, therefore, an integral part of life and not just a process of death.

Sickness also was created to warn man that life is not eternal. Whatever man can do in this world will stay on after he departs. Therefore, the thoughts of the patient are not only occupied with his illness but also concern themselves with his eternal life. The sickness serves to bring man closer to his Creator and he becomes aware of his insignificance. He begins to grasp that there is a Leader in this world, who has it in His power to shorten or to lengthen human life. Suffering cleanses man of his sins, in order that he may depart from this world with "clean hands and a pure heart." Therefore, our sages say that a man is not healed of his sickness until his transgressions have been forgiven. We have been given a vivid illustration in the Talmud Shabbat (32 a) of the spiritual status of a sick person.

> A man who goes to the market is like a person who has been delivered for judgement. If he has a headache it is like he were standing before a justice and tried for life. If he climbs into his bed and falls it is as if he were pulled up on the guillotine for sentencing. If someone has been called for sentencing then he is saved if he has good advocates, but if not, he will be executed. The main defenders are repentance and good deeds.

From this we understand that anyone who has been healed from an illness must value his life, know how to utilize it, understand what to do with it, and recognize from whom he has received his life.

3 The Patient and Visiting Sick People

As we have seen above, illness does not serve just to remove a patient from his normal condition but rather lends meaning to his new status. It has a deep significance: it comes to purify him and to procure for him happiness when he recovers and regains his evaluation of the meaning of life. The illness strengthens the direct communication between the Creator and the patient. He has suddenly become aware of his own insignificance. In a minute he has been converted from a strong hero, who is active and influences his environment, to a creature who depends on everyone's help. He returns to his childhood years, to the days when he was cared for by others. This idea, or rather this feeling of dependence, can bring him to a complete breakdown.

This sudden feeling of inadequacy, coming after years of active awareness, can bring him to a dangerous spiritual downfall, which may worsen his state of health and hasten his end.

The physical realistic condition of the patient determines the medical treatment and, yet, it is well known that the will to live and the striving to fight against the sickness influence his medical well-being. Therefore, it is our responsibility to encourage the patient to realize that there is a purpose to his life, even under such conditions, and that the illness should not defeat him. He is still the same person, and there is still hope that he will return to the normal way of life. His need for aid is not unique as all of us are dependent, to a smaller or larger degree, on our surroundings. It is written in Genesis (2: 18) "It is not good for man to be alone. I will make for him a suitable helper."

Since the Torah is a guide for our *entire* life, it must, and does, give solutions to the problems of the sick person. It plunges into the depths with the patient, understands how he feels in the innermost parts of his heart, and then guides him in finding solutions to his problems. For example, it is written in the Talmud (Tractate Nedarim 40 a) that the Holy One Himself feeds the patient. He is not really dependent on others and it not a burden to society, but rather he is elevated to a new station and God Himself nourishes him.

Another maxim quoted in the above talmudic portion is that the Divine Presence hovers over the bed of an ill person. Thus, the patient and his illness serve as a reason for the presence of God. The broken heart of the patient and his wish to cleanse himself bring him nearer to his Creator. He suddenly begins to realize that life is more than the search for happiness and pleasure and seeks to return to a better way of life. But to be exact, the sickness does not bring the person closer to God, but rather brings his Creator closer to him. He becomes aware that he is not isolated in his pain or his grief and the Divine Presence is there to give him a feeling of security. He prays to God and is certain that is prayers will find a receptive ear. This fact helps him to overcome his feelings of hopelessness and aloneness.

As a result, the patient reaches a higher status as a man, who communes with his Creator, and a visit to him is, therefore, of great spiritual importance. We know that the Almighty visited Abraham after he circumcised himself (Genesis 18: 1), and we are commanded to act in imitation of Him. That is, visiting the sick is not only a deed of benevolence, but an act which brings the visitor to a higher level of devoutness. The sick, therefore, must be made aware, that he should not consider himself a burden, but must realize that he is giving his visitors an opportunity fo fulfill an important commandment, and, at the same time, to be in the Holy Presence. Because of the importance of this, our sages list visiting the sick as one of the ten things which we plant in this world and reap rewards for in the world to come. There are various facets to these visits: first of all he must encourage the patient and try to find suitable words, which may heal him more than medicines. Therefore, our sages say that everyone who visits the sick removes $1/60$ of the illness (Talmud Nedarim 39 b). However, in order to fulfill the commandment in its entirety, it is not enough to visit him only but one must do something concrete to help him. For example, if one helps a patient to lie in a clean and orderly room, it gives him a feeling of being less dependent and he is not ashamed of other visitors. Lying in a clean room and bed lends dignity to his self-image. It is told in the Talmud that when Rabbi Akiva visited his sick students he swept their rooms. His students said, "You have revived me." Where upon Rabbi Akiva published the following maxim, "Everyone who visits the sick causes him to live and everyone who does not visit him can be likened to a murderer" (Talmud Nedarim 40 a).

Every time one visits with the sick he fulfills a new commandment, on the condition that he does not cause the patient any inconvenience. He should, therefore, find the suitable time for his visit in order that it accomplish its purpose. Furthermore, it is the task of the visitor to help the patient to review his past to help him to repent and to prepare him for departing from this world. Only a person who is an expert in this can help him to confess his sins and yet to avoid causing him too much mental anguish. This is done in order to allow him to feel serene and to help him to face his future.

To sum up, the sick person has a holiness, the Divine Presence is close to him, and everyone who occupies himself with the patient receives part of this holiness.

4 The Doctor and the Nurse

Since all people are holy creatures, and the Divine Presence is close to the sick, it is a holy obligation for the doctor and the nurse to take care of the patient in a suitable manner. This is a privilege, not a profession. The doctor is there to fulfill the task of the Almighty, who heals the sick and has passed this task on to those privileged to substitute for Him. It has thus been declared in Yoreh Daya (331 A): "The privilege has been given to doctors to heal; this is a Mitzvah - a commandment, and he must save lives. If he withholds this ability to save lives, it is as if he would shed blood." The doctor may not argue that others of equal ability are available, since it may have been destined that he is the one to save this person. Furthermore, the patient may have a special confidence in this doctor and not in another, and this mental attitude is part of the process of healing. It is self-evident that because of the demands of the profession, only these who have the ability and the inclination take upon themselves this task. Our sages compare a doctor to a judge, since his task is as holy and elevated as that of a spiritual leader. It is forbidden to live in a city that has no doctor. There are, therefore, instances of wise experts of the Torah who were also doctors, such as Maimonides and the Nachmanides, because they recognized in medicine a holy task. It is interesting to read the prayer for the doctor which is attributed to Maimonides:

> You have also chosen me to keep watch over the lives of your creations and over their health. I am now going to fulfill my assigned task. Help me, oh merciful God in my holy task and let me succeed, because without your help man cannot succeed even with the smallest deed. Fill my soul with love for the profession and for your creatures. Don't allow love of gain, fame or honor to disturb my work, because these are the enemies of truth. Let me see the patient as a human being, because that is what he is.... Fill the hearts of the patients with confidence in me and that they, therefore, will listen to my advice.... Let the world not awaken in me the thoughts that I have great knowledge but give me strength, time, and the will to continually improve and to acquire new knowledge. The scope of this profession is great and the understanding of man is unlimited - it always strives to improve. In my knowledge of yesterday I will often reveal mistakes today, and that of today will be found to be mistaken tomorrow. Strengthen me in this great task so I may succeed.

This prayer expresses the status of the doctor and the weight of his task.

All of this applies even to a greater extent to a nurse. The doctor decrees, but the nurse has to execute. She has the privilege that without her performance there is little value to the doctor's advice. She truly fulfills every minute the commandment of visiting the sick, in its fullest meaning. She helps the ill, washes him, feeds him, so that without her a patient can nearly not exist. She has to understand how important her task is and how great is her responsibility. The eyes of the patients are glued upon her with hope. But when he senses that she does not hear him, he becomes depressed and gives up. Her responsibility is tremendous, since every little mistake in the treatment may have terrible consequences. However, she has to have confidence that if she has indeed the right intentions and follows the correct instructions her work will surely be pleasing and God will support her.

There is no doubt that if the attitude toward the patient is looked upon as a holy duty, the treatment will be serious. The devotion and the effort of the doctor and the nurse toward the patient will be more effective if they remember that the Divine Presence supervises and helps them.

The Implication of Radical Christian Philosophy for Nursing Ethics

L. R. Uys

1 Introduction

Ethics is not a special science that can be handled as a separate entity. It is based on philosophical cosmology (world view) and philosophical anthropology (view of man). The starting point of the study of ethics or an ethical enquiry should, therefore, be the basic philosophical stance of the individual or group. The radical Christian philosophy, or the philosophy of the Cosmonomic Idea, is taken as an example to show the influence of its basic tenets on nursing ethics.

Very briefly, the cosmos, with man as its crown, is seen as having the holy will of the Creator God as origin. This cosmos is a coherent totality of identity structures, which include all sorts of things: plants, animals, and men. All these structures exhibit a number of modal aspects. The law of God for the cosmos is the boundary between God and creation. The cosmos was created by God unto Himself and, therefore, the essence of all creation is its relationship to God - the religious dimension. The cosmos has four dimensions: the religious dimension, which is the central depth dimension concentrated in the heart of man; the time dimension; and the dimensions of modalities (or aspects) and identity structures. Fifteen modalities have been identified, each of which has a unique meaning kernel. The first six aspects are called natural aspects, because their laws are natural laws to which everything is subject without choice. The rest of the aspects are called normative aspects, because man has a choice to obey or to disobey its laws (norms) (see Fig. 1). Modalities are mutually irreducible: they are governed by the principle of sphere sovereignty, that

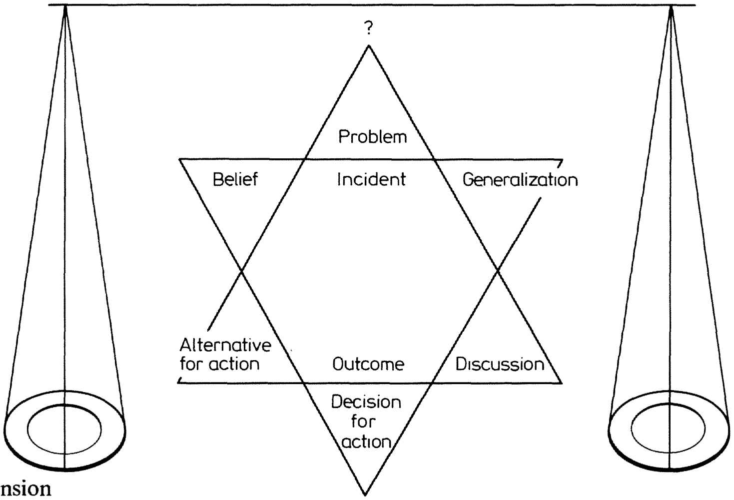

Fig. 1. Modal dimension

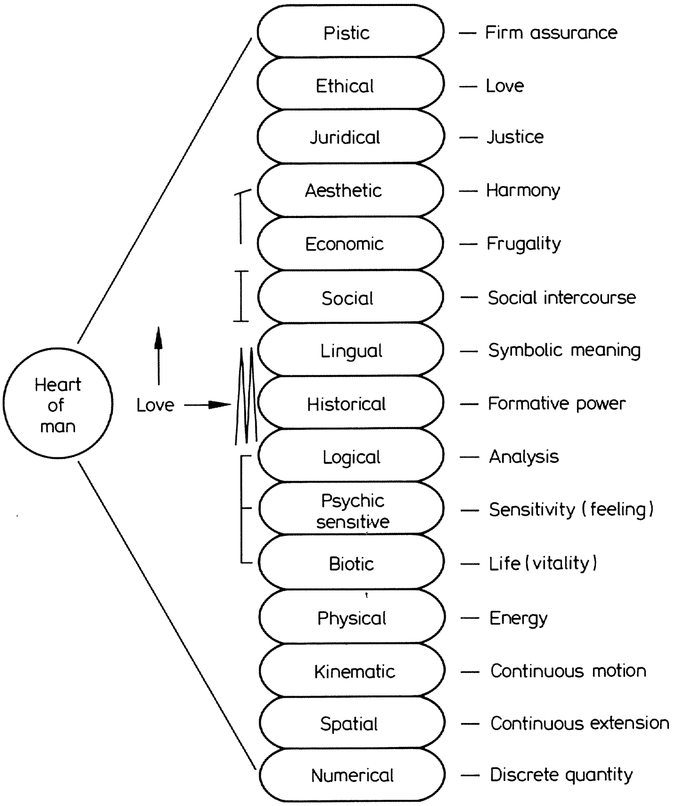

Fig. 2. Modal structure

is, the laws of each aspect are sovereign within its own boundaries. But they are also all connected by the principle of sphere universality. This principle calls attention to the fact that each aspect mirrors all the others through analogies (anticipations and retrocipations) drawn between them. In every modal sphere two sides can be distinguished (Fig. 2). On the one side there is the law or norm which is peculiar to this modality; on the other, there is whatever is subject to this law or norm.

2 Ground Motives

In this system the whole of man's functioning, including his scientific endeavors, is seen as emerging from a fundamental, religious ground motive. A ground motive is the central, pretheoretical preconception of a person, which is concentrated in his heart. This merely means that no person (or scientist) can think other than out of his heart (his self or being), which is pretheoretic.

A number of ground motives active in Western thought have been identified, starting with the Greek motive and then the scholastic motive. The most pervasive ground motive of our time, however, is the humanistic ground motive. It is a dialectic motive with the two poles being nature (or the science ideal) and freedom (or the personality ideal). It assumes that man is autonomous and free through mastering nature with the help of science. The inner contradiction between the ruthless determination of science and the freedom of man leads to a continuous vacillation between the two poles. In ethics we have very good examples of people representing each pole. Skinner [4] represents the science ideal. He says that there is no inherent right or wrong; these are just terms we use to shape the behavior of people.

> Freedom and dignity ... are the possessions of the autonomous man of traditional theory, and they are essential to practices in which a person is held responsible for his conduct and given credit for his achievements. A scientific analysis shifts both the responsibility and the achievement to the environment [4, p 30].

Science reigns supreme. At the other extreme is Fletcher with his situational ethics in which autonomous, rational man is free to decide for himself without legalistic rules [2]. In the writings of some ethicists both poles are represented. Moore, for instance, tries to make a synthesis between facts (science) and values (freedom) [3].

The Christian ground motive is that of creation, fall, and redemption through Jesus Christ and the Holy Spirit. The influence of this ground motive is firstly that the Creator God has laid down a cosmic law for order in His creation, and this was not changed by man's fall into sin. Thus Christian ethics may never be allowed to be relativistic. The fall into sin, however, meant that on the factual side of creation, man can be faced with collision of duties. This means that in a certain situation both options open to a person may be wrong (sin). Redemption means that forgiveness is available through Jesus Christ and guidance in each situation is available through the Holy Spirit.

In an ethical argument, the ground motives of the different positions have to be analyzed. This process is called transcendental criticism and is essential to understanding and evaluating different ethical systems.

3 The Ethical Modality

Ethics has often been equated with normative behavior - what man ought to do. From this scheme of the modal dimension (Fig. 1), it becomes clear that not all normative behavior falls within the ethical realm. There is also behavior that is logically right or wrong, linguistically right or wrong, or economically right or wrong. This does not make all these behaviors ethical in nature. Ethics can thus be defined as the science which identifies the ethical modality and differentiates it from other aspects. This includes identifying and describing its meaning kernel (love), its anticipations and retrocipations, as well as situationally and structurally typical norms.

If the ethical aspect is not given its rightful place, one of three things can happen: the ethical can be reduced to some other aspects, repudiated, or over accentuated.

3.1 The Ethical Can Be Reduced to Some Other Aspects

Quite a few examples of this reductionism can be identified. The naturalistic ethics of Rousseau (and Freud), which defines right as being that which gives the natural aspects free reign and restricts the normative aspects, reduces the ethical to the natural aspects. Historicism, which sees right as those norms which have developed through certain historical processes and for certain groups, reduces the ethical aspect to the historical aspect. Ethical emotivism, which defines right and wrong as emotions elicited by certain actions, reduces the ethical to the psychic aspect.

3.2 The Ethical Can Be Repudiated

The existentialists (Heidegger, Jaspers, Satre, and de Beauvoir [1]), with their strong focus on existence, are not interested in the essentials of the ethical. Simone de Beauvoir talks about a morality without content, because when a definite content is ascribed to the ethical, the "freedom" of man is curtailed by "what should be." This viewpoint denies the ethical aspect of man's nature.

3.3 The Ethical Can Be Overaccentuated

When the ethical norm of love is allowed to spill over its borders and to encroach into the sphere sovereignty of other aspects, disharmony ensues. The strong focus in the health world of today on the rights of man, without considering his responsibilities, is an example of such a overaccentuation of an ethical norm [5].

Disturbing the balance among the different parts within the modal structure of the ethical also leads to different "isms": denying the norm side leads to relativism, overaccentuating the subject leads to subjectivism, and overaccentuating the factual side leads to irrationalism.

4 View of Man

Christian philosophy believes that God created man after His own image. Man's existence is concentrated in his heart, which is premodal, prestructural, and eternal. Man's body has four structures which are interwoven without each strand losing its own characteristics: a normative, typically human, personality structure; a psychic substructure; a biotic substructure; and a physiochemical substructure. These four structures make an indivisible whole: the soul-body dualism is rejected for the sake of a duality. (The question of when ensoulment takes place, which is so important in abortion arguments, thus does not arise.) God placed man in the center of the universe and gave him a cultural mandate to cultivate and rule over the earth.

Man is a normative being. This means that he was created with the free responsibility to positivize creation principles into norms. A principle refers to the origin or source of something. Cosmic principles are the modal and structural preconditions for human existence. Man can never withdraw himself from them - he cannot be "a-ethical" or "a-biotic." Cosmic principles must, however, be positivized (or concretized) by man into norms. Positivization is free form-giving by a human being on the ground of discriminating formative authority (capacity) and is dependent on the stage of cultural development. A norm is a rational, temporal standard of what ought to be. When a norm is obeyed, a value is realized. Values are acts, events, concrete, and products of norms. "Values are referential in character and only in this reference to the law-order do they possess any meaning" [3 p 187].

This dynamic relationship among cosmic principles, man, and norms makes it clear why no casuistic list of rules can be acceptable as an ethical system. The nurse has to take the ethical principle of love, study the structures and situations in which she is placed (these include her culture, the health care system, her profession, the legal system, and the client system), and responsibly positivize norms which are historically relevant. She must realize that norm variability is a retrocipation to the historic aspect and does not mean that she is being relativistic. She must also remember that when she is working with human beings, their normative and eternal nature must be respected. Of course there will be chaos if every nurse does this individually, but groups should get together for this task.

It is impossible to make well-grounded ethical decisions without first taking an in-depth look at one's own view of man.

5 Conclusion

This presentation of the philosophy of the Cosmonomic Idea was given to show the far-reaching influence that the basic philosophical stance has on ethics. Although a study of philosophy to find a system with which one feels comfortable may sound like a tall order, I believe that nursing science can no longer accept a prescientific intuitive approach to its ethical problems. We must take time to give nursing ethics a solid philosophical foundation.

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V. Epilogue

Introduction

When the nurse practitioner became a more independent person, leaving the protective and overpowering shadow of the medical doctor, rights as well as obligations were gained. Not all treatment settings are uniform in this newly developed dependence-independence model; institutions, hospitals, homes etc. each have their own very different ways of dealing with this issue.

An interesting concomittant issue that arises with the autonomy and greater responsibility that nurses have attained is the moving-up the ladder of responsibility and hierarchy by paraprofessionals and practical nurses. These workers are now assuming a greater role in clinical nursing.

The papers in this section, from Israel and South Africa, look at the nurse practitioner in relation to the "self" as well as the "other" - in regard to dependent, independent, and interdependent functioning. This section ends the book with provocative questions with regard to health care resources, on what basis are services allocated, and ethical determinations for receiving/giving care.

The Dependent, Independent and Interdependent Functions of the Nurse Practitioner: A Legal and Ethical Perspective

C. Searle

1 Introduction

In general, contemporary nursing literature from Western countries does not take a bold stand on the very controversial issue of the dependent and independent functions of the nurse practitioner. The authors write as if they are skating on very thin ice. Textbooks on nursing imply a great deal about the practice potential of nurses but ever and anon there is a subtle reversion to the concept that nursing has certain dependent functions, meaning functions that require a doctor's authorization, and certain independent functions that are carried out on the nurse's own initiative and responsibility. In general the majority of authors consulted appear to subscribe to the concept postulated by Sarney when he says: "A good nursing practice act will separate the independent functions (what a nurse can do on her own) from the dependent functions (what she can do only, under the direction of a doctor)" [6].

I question this standpoint. We are living in an era of multidisciplinary teamwork in the health field. In this team the *patient* is the leader of the team, not the doctor, although the doctor has certain, specific levels of expertise that other members of the team do not have and, in consequence, makes the major diagnostic and therapeutic decisions. These decisions have largely to be implemented by other members of the health team. In this sense he then "assumes direction" of the total health care program. Yet, in my country at least, there is no law that says he *is* the leader, for chiropractors, psychologists, osteopaths, nurses, and midwives all have the legal right of practice. All these professionals may call the doctor in to share the decision-making process, treatment, and care of their patient. In some cases he may refuse to do so.

2 The Question of the Dependent, Independent and Interdependent Functions of the Nurse

It is precisely this position that raises the question of the dependent function of the nurse being one that is dependent on the doctor.

I believe that the functions of the nurse should be described as *dependent, interdependent,* and *independent,* with a shift in the traditional meaning of the dependent function.

The *dependent function* of the nurse is based on the law which authorizes her practice and on common law and relevant statutory laws. It is not based on that which the doctor prescribes, requests, or directs for the patient. In accepting such direction or prescription the registered nurse acts as a professional person and is responsible and accountable for her own acts and omissions.

Without the observance of the provisions of the nurse practice act, she becomes criminally liable and without the observance of other health-related legislation she may become civilly or criminally liable. The law is the system of rules that provides order in professional practice. It is the law, and only the law, that authorizes her professional acts. She is dependent on the law for every aspect of her professional role and function. I must emphasize that the locus of the dependent function of the nurse is, and remains, the law empowering her to practice. This includes the regulations made by the subsidiary legislative authority, namely, the professional registration and controlling authority (in my country, the South African Nursing Council). It further includes decisions given by the courts anent the interpretation of such laws.

The *interdependent function* relates to the interrelationship of the nurse with the patient and with other members of the health team. In particular it relates to the interdependence of nursing and medicine. The nurse, whether as institutional practitioner or as private contractor, is not the servant or subordinate of the doctor. She is a registered nurse practitioner, entirely responsible and accountable for her own acts and omissions to the registration authority, the South African Nursing Council, and in the broader sense, to the courts. Where she accepts a prescription, request, or direction for treatment of a patient from a doctor, she does so as an independent practitioner on behalf of her patient and she has a shared responsibility with the doctor. She acts in the interests of her patient and in so doing has a joint responsibility with the doctor for ensuring that the patient is receiving the prescribed diagnostic and therapeutic care as well as the relevant nursing care. In other words, *the patient is her patient* as much as he is the patient of the doctor. She cannot distance herself from this elementary fact. Doctor and nurse have an interdependent and reciprocal responsibility. Neither can provide all the health care the patient needs. It is a joint as well as a broader team effort. In this respect a very substantial element of coordination of team activities is done by the nurse in the interest of the patient. The interplay of activities between doctor and nurse epitomizes the interdependence of their functions.

The interdependent function is clearly recognized in the various health professional registration acts and in the regulations made thereunder. It is interesting to note that in South Africa, interprofessional cooperation is limited to those professions that are duly registered or enrolled under Act of Parliament, that is, those that are dependent on legislation for their practice. Within these parameters all participants in any patient care situation have mutually interdependent, but also independent, functions. Throughout such interdependent action the nurse remains responsible and accountable for her professional acts of commission or omission.

The *independent function* of the nurse has two dimensions. One dimension relates to all those aspects inherent in nursing diagnosis, treatment, and care which are the normal prerogatives of the nurse. The other dimension is concerned with the manner in which she carries out any of her duties as a registered nurse, whether this be an independent or interdependent function. Whatever she does, she does on her own responsibility and accountability, for in law she is personally liable for her acts of omission or commission. *She* and *she only* remains accountable for her actions. Only she can decide whether she is legally able, or knowledgeable and competent enough, to accept a specific prescription or direction from a doctor or is able to participate in the care provided by other members of the health care team. Once she has indicated acceptance she has made an independent decision and accepts full responsibility and accountability for her decision and actions. Even her decision to observe the provisions of the nurse practice or related laws is an independent function for which she is personally responsible and accountable. It is important to note that neither the nurse nor the doctor nor any other member of the health team is an autonomous practitioner, for such a practitioner does not exist. All the members of the multidisciplinary health team are responsible and accountable to the patient, the registration authority, and the law of the land, which is the vigilant sentry before the door of everyone's professional life. All are accountable, and if one is accountable one cannot be autonomous, be one doctor, nurse, psychologist, social worker, physiotherapist, or any other member of the health team.

The nurse is solely responsible and accountable for her own practice whether this be in a fee-for-service situation or in a salaried situation where she has to accept responsibility for a number of patients. This is the basis of her professional practice in South Africa. Her independent function supersedes and indeed pervades her interdependent function (South African Nursing Council Regulations, 1950).

From where does she derive this authority, this delineation of function? These three functions are squarely based on the law governing the practice of medicine and of nursing in South Africa and on legal decisions which have been given by the courts in law suits involving patients, doctors, and nurses [5]. Without such laws and legal decisions, professional practice for all health professions would be chaotic. These laws are not a restriction upon the freedom of a professional, but a gateway to greater freedom, for they establish certain rules that the health practitioner may not transgress. These laws are made to free the professional, not to bind him, by telling him what he may do without transgressing on the equal liberty of other health professionals.

3 Exclusive Right of the Doctor to Clinical Responsibility Not Established in Law

In South Africa, the Medical, Dental, and Supplementary Health Service Professions Act 56 of 1974, as amended, governs the practice of medicine, dentistry, psychology, and the supplementary health professions. Nursing, midwifery, pharmacy, and chiropractic are *not* supplementary health professions. They are professions in their own right with their own practice acts. The Medical, Dental, and Supplementary Health Service Professions Act prohibits any person who is not registered as a doctor, excluding persons registered under the Nursing Act and the Chiropractors Act, performing any act whatsoever having as its object the diagnosing, treating, or preventing of any physical (including mental) defect, illness, or deficiency in any person, including the giving of advice in regard to such defects, illnesses, or deficiencies, or the prescribing or providing of medicine in connection with such defects, illnesses, or deficiencies (the Medical, Dental, and Supplementary Health Service Professions Act 56 of 1974, Section 36).

Provision is also made in the Nursing Act setting out under what circumstances, which are not *emergency situations,* nurses may be authorized by the Nursing Council to prescribe and provide scheduled medicines or to prescribe and provide *medical* treatment (as distinct from nursing treatment and care and as distinct from emergency health care) in the absence of a doctor or pharmacist (Nursing Act 50 of 1978 as amended by Act 71 of 1981, Section 38 s). The extensive gray areas between nursing and medicine where there is overlapping of the functions which can be performed with varying levels of knowledge and skill is thus duly recognized in law.

In a free enterprise health care system, such as exists in South Africa, the law and its regulations impose certain limits of action upon both doctor and nurse. Both may charge fees for patient care, but neither practitioner is free to charge the patient an unlimited fee that he or she may wish to impose. The maximum fees chargeable in private practice are prescribed by the Medical and Nursing Councils respectively. Neither may such practitioners "enter into an agreement whereby the patient undertakes to assume responsibility for negligent treatment" [10 p 317]. All registered health professionals, including the doctor and the nurse, are not only dependent on the laws and regulations authorizing their practice but within the ambit of their professional code of ethics cannot perform professional acts for which they are "not adequately trained and/or insufficiently experienced except in an emergency" [11]. Common law is explicit in this regard, namely that "a practitioner who performs such acts may be held liable for damage or injury suffered by the patient in consequence there of on the basis of negligence" [11]. This is a very powerful inducement to responsible action in which the practitioner has the independent function of personal responsibility and accountability. Nothing in an agreement between doctor and patient requires the doctor to provide all the care the patient needs, for clearly in the multidisciplinary team context, and in the very nature of modern total care, this is unthinkable. The doctor cannot and does not have sole clinical responsibility for the patient.

In a country with a well-regulated health practice system, some authority has to authorize practice and assign responsibilities. In South Africa, this is done by Parliament, which enacts legislation for the regulation of the various professions in the interests of the public [10 p 9], and on this legislation the professional is dependent.

4 Nurses Must Take a Stand on the Meaning of the Dependent, Independent and Interdependent Functions

For most of nursing's long history there is evidence that nursing has always had this three-dimensional basis of practice. Let me try and sketch this assertation.

4.1 The Three Functions in Preliterate Society

In preliterate societies the locus of authority for any action relating to a member of the family rested with the head of the family and through him to the extended family, the clan, or the tribe. This was from where the dependent function stemmed, namely, the law of the head of the family. The independent function related to the care provided by the responsible family member who had to exercise great responsibility and accountability in carrying out such care. The interdependent function was very much to the fore, for within the particular social pattern, the provider of care had very definite interdependent responsibilities with other members of the extended family or clan and with the traditional healer.

4.2 In Early Hebrew Society

These selfsame functions are epitomized in the early Hebrew period by the legal and ethical stance adopted by the midwives Şephra and Phua who disregarded the injunction of the Pharaoh that they had to kill all the newborn male infants born to the people of Israel. Awareness of the temporal laws of Egypt, but utter obedience to the laws of Jehovah, close interdependence with the leaders and teachers of their people, and independent action by the midwives characterized the actions of these midwives (Exodus 1: 15-21).

4.3 The Hippocratic Period

We see a new development in the Hippocratic period where there appears to be a shift away from this approach. Shryock quotes a translation which indicates the need for, and the position of, the nurse with reference to instruments used in an operation. "But if another gives them he must be ready a little before hand and do as you direct" [9]. Clearly this indicates a position dependent on the physician. It has not been possible to trace what the measure of responsibility and accountability was in such cases. It appears that the physician assumed an all-powerful role. I may be wrong in my deductions.

4.4 The Early Christian Period

The monastic, crusader, military, and secular nursing orders were all dependent for the provision of health care on canon law, or the laws of the church, and the rules of the respective orders approved by the church. These orders all acted on the Christian ethic, as exemplified in Christ's teaching that identified the love of one's neighbors with the love of God in his promise that "inasmuch as ye have done unto the least of these my brethren, ye have done it unto me" (Matthew 25: 40). With the words "I was sick and ye visited me" (Matthew 25: 36) nursing was lifted to a plane of moral obligation and an ethical tradition was born. The locus of authority was canon law, on which the dependent function of the nurse was based. A very strict interdependent function existed with other members of the religious order who shared patient care and with the priests for spiritual care, but within these parameters the provider of nursing care had the independent function of diagnosing, prescribing, and providing treatment and care, and of ensuring that her interdependent functions were carried out within the dictates of the policy of mother church. For all this she was held responsible and accountable to the superiors of the order and to the mother church. The above pattern also flourished in feudal times when the lady of the manor provided care within identical parameters.

Throughout the long history of the Christian church, the men and women who carried the Christian faith and Westernized healing services to all corners of the earth provided nursing within these parameters. Common law apparently made little impact on their practice. Canon law was the foundation on which they built: it was their sole source of authority. It was the nineteen and twentieth century developments that highlighted the common law components of practice and brought statutory foundations for the practice of nursing and medicine.

In all these periods of nursing history, except perhaps in the Hippocratic period, accountability was a well-entrenched concept. Sanctions of some kind or other always existed and could be imposed on those who failed in their accountability.

4.5 The Dark Ages in Health Care

The eminently logical and orderly system of health care provided under canon law fell into disuse at the time of the Reformation, when the care of patients was wrested from the hands of the great religious orders. Felons, indigents, drunken slatterns, even other patients provided such care as existed in the Poor Law institutions. Chaos in the institutionalized care of the sick threw the functions of the provider of nursing care into disarray, with no clear distinction between the functions of a nurse and the functions of the lowest grade of domestic servant.

4.6 The Nightingale Era

When Florence Nightingale came on the scene in her struggle to reorganize hospitals and health care systems, and working as she did within a military system, she totally sacrificed the potential legal functions of the nurse "to the orders of the doctor," i.e., to the military orders of a military officer. She required total dependence and absolute obedience to the doctor within a military hierarchical system. Moreover she required the submissiveness akin to that of the religious sister as well as the unquestionable obedience of a person in the military system who was subordinate to the officer class. To enforce respectability in nursing she had to require rigid observance of military discipline and orders. In the process she undermined the professional development of nursing, even after legislation was enacted for registration of nurses and the nurse was given a legal role of her own. She started the concept of the nurse having a function dependent on the doctor. With the wisdom of hindsight, we lay this accusation at her door, forgetting that we, who have lived in an era of professional registration of nurses, have happily perpetuated this myth. Our sin is the greater!

The pernicious concept of the function of the nurse being dependent on the orders of the doctor was carried to every part of the world where the Nightingale system penetrated. By five words "the orders of the doctor" uttered in a male-dominated, Victorian, military milieu, nursing practice was denied its legitimate professional rights and responsibilities for many decades. In some parts of the world this concept still persists.

4.7 The Nurse as the Tool for Reorganization of Hospitals

In the struggle to reorganize hospitals and to keep the costs of this as low as possible, the nurse was made the tool for such reorganization. Her own professional rights and responsibilities were ruthlessly denied her, even after legislation was enacted enabling her to be a professional practitioner in her own right with only one source for the dependent dimension of her practice: the law.

The training system ensured that a docile, brainwashed, manageable person, ill-equipped to fight for her professional rights, provided the cheap yet disciplined and well-skilled service that enabled hospitals to exist, medical schools to flourish, and medical practitioners to grow prosperous on the sweated labor of the nurse. The myth that the nurse is dependent on the medical practitioner for the authorization of her practice, and that she is subservient to him, persists despite legislation to the contrary. This approach resulted in the nurse seeking power and authority in the administrative system of the health servive. She relegated the all-important clinical function, which is basic to the authorization for practice, to a secondary place. Evidence of this abounds around the world. Until the nurse recognizes the error in this approach she will not understand the three-dimensional nature of her function and will not appreciate the vital importance of her dependent function that has its locus in the law.

5 First Professional Registration of Nurses Located the Dependent Function of the Nurse in the Law

The very first legislation in the world to recognize nursing as a profession and to register nurses was enacted by the Parliament of the Cape Colony (now the Cape Province of South Africa) on 21 August 1891. This Act (the Medical and Pharmacy Act 34 of 1891) provided for the registration of nurses and midwives on the same register as medical practitioners, dentists, pharmacists, and druggists. It provided such basic principles for the registration of a professional person as training, examination, certification, registration, disciplinary control, recognition of further study and qualification, protection of the rights of persons registered, as well as the protection of the public to be served. This law and its relevant regulations provided for the cancellation of certificates and the withdrawel of the right of practice for incompetence, negligence, acts of omission and commission, and conduct unbecoming to a professional person. All this required an independent function and accountability.

Despite the fact that the law clearly delineated the nurse as a separate category of practitioner, responsible for her own conduct and practice, the myth persisted. I believe the myth persisted for an ethical reason that had a very heavy overlay of etiquette. The nurse makes a commitment to patient care that goes beyond her own feelings. She subscribes to both the negative apodosis of *primum nocere,* doing no harm to the patient, and the positive protasis, ensuring benefit for the patient. These have their origins in the Hippocratic concept of being helpful and doing no harm. In the quasi-religious, quasi-military atmosphere of the reorganized hospital service, the nurse was enjoined to observe the strict etiquette of acknowledging the seniority of "the medical officer." In time she saw this as an ethical obligation, denying her legal dependent function and her own independent function in the process. Nevertheless, in the de facto situation she adroitly exercised her independent function without raising any dust about it. It took several lawsuits in South Africa, as well as the establishment of the South African Nursing Council, through the enactment of the Nursing Act 45 of 1944, to bring it home to the nurse that only the said Council, empowered by the law, can determine what her practice is, and that she is personally responsible and accountable for how she exercises her dependent, independent, and interdependent functions. This is slowly being recognized by the doctor and the nurse, but such change is long-drawn-out, for it is part of the overall societal change in my country.

Professional Legislation in South Africa

- The Medical and Pharmacy Act, 34 of 1891
- The Nursing Act, 45 of 1944
- The Nursing Act, 50 of 1978 as amended by Act 71 of 1981
- South African Nursing Council Regulations - Acts and omissions of registered nurses. G N 1650 of 14 September 1972 ad amended by G N 481 of March 1978: 1
- The Medical, Dental, and Supplementary Health Serivce Professions Act, 56 of 1974 as amended
- The Chiropractors Act, 76 of 1971
- The Homeopaths, Naturopaths, Osteopaths, and Herbalist Act, 52 of 1974
- The Pharmacy Act, 53 of 1974
- Miscellaneous Acts relating to the provision and control of health services, medicine and drugs, abuse of dependence-producing substances, hazardous substances, organ and tissue transplants, birth, marriages, and deaths, abortion and sterilization acts.

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The Changing Role of Nurses and Its Implications

D. Michaeli

Nurses resent the image of "physicians helpers" as still seen by the public in general. They demand to assume partnership in responsibility for decision-making concerning patient management. In England in a paper in the British Medical Journal the author says such decisions are made only by physicians and social workers while other professions, including nurses are devoid of the possibility to interfere [1].

One attempt at changing this situation was made by replacing older nurses with younger nurses. Since such nurses did not have enough experience to be able to acquire on informal influence, they put the emphasis on administrative (bureaucratic) intervention rather than on clinical nursing, and their influence on the decision-making progress was small.

In the United States the notion of "the nursing process" was developed. This includes: evaluation of the patient's needs, planning the management, performing the nursing itself, and evaluation of success. The process starts by taking a "nursing patient's history" and the nurse is personally in charge of the patient for all the management. Many nurses resent the amount of paperwork which is involved. But, there is a general trend with the more influential leaders among nurses to give the nurse the responsibility for establishing standards and more authority. This of course goes along with the question of the nurse's *accountability* for her deeds and her decisions, being more independent of the "coverage" of the physician.

The problem of the nurses who struggle to achieve a status equal to that of physicians is a real one. Nursing is establishing itself as an academic entity with masters degrees and doctorates in nursing. Such graduates tend to achieve that status which they "deserve."

Nursing is struggling to develop its own theory and practice and its own research. Nurses now openly claim their right to assure the role of *head of health teams*. While they do not look upon themselves as a *"subentity under medicine,"* they claim their independent status and power similar to other academic professions.

While nurses themselves realize that nursing as an academic profession is not yet ready to assume this status and responsibility, they believe that "medicine" should learn to live with the idea of complete equality in status and power and adjust itself to a new situation [2].

I wish to challenge the nursing profession and to suggest that this trend carries within itself the very seeds of the troubles which when growing-up will be counteracting these idealistic and simplistic attitudes of those deans of nursing schools and other leaders of nursing who, in their enthusiasm, disregard realities of the health delivery systems.

I really do not object to any nurse or any other health professional who wants to be responsible for clinical care of patients. If they want to assume full responsibility for diagnosing and treating patients, they should study medicine, get the license, and do it. I really don't believe there is either a place or a need for a parallel development of nurse-healers. This does not mean that nursing as such should not develop its own research, theory, and practice. I really believe that "academization of nursing" is a fact and the problem now is to try and study what should be the future of this nursing profession and in what direction it should develop. It is not just a game of power and politics. It is too important to leave it at this level.

The trends to nursing are in many ways similar to those seen in medicine and they are the result of technological development and over-specialization. Once the academic nurse is qualified she should either develop and progress with science and technology or be lost and deteriorate and loose her status. The result is a detachment of the nurse and her drifting away from many traditional roles and tasks, which do not satisfy the ambitions of the sophisticated modern nurse. This creates a vacuum that is already being filled by nonregistered "nurse aides." On the other hand "intensive care nurses" and other specialist nurses create a new problem. If we say that in a general hospital up to 8% of the beds are intensive care beds, they need (in Israel) 24% of the nurses of the hospital. We are already incapable of supplying this number of qualified specialists and we drain too many qualified nurses from the general wards to these units. Can we go on like this? The answer is "no" and the solution is to create new professions of "physician-helpers" (like "physician assistants" or "paramedics" and other "health technicians") who will eventually replace the traditional nurse, while the qualified nurse will be directed toward the more interesting jobs in patients' care.

The nursing profession is fighting against this trend but does not offer any solution. Nurses fight this battle on a pure "professional-labor-union" basis with a lot of "cotton-wool jargon" and demagogy and little substance. Yet, if nurses don't want to understand it and adjust to reality they will soon be faced with a new world they may not like at all, but with which they will have to live.

In the nonsophisticated health systems like geriatric or psychiatric institutions, there is little room for the academic nurses and very few such nurses will find their place there. This is going to be a vacuum again and will be filled in by other people who will develop a new health profession of physicians helpers. So if nurses don't like to act like physicians helpers they must think about who is going to assume this role in the future, because these professions will take the place of the nurse. It may be called "helpers," "aids," "technicians," "paramedics," "physician assistants," or any other name, according to their formation, preparation, education, and role, but in fact they are already here with us and they are going to stay.

Another problem for the nurses to cope with is the polarization within the nursing profession. The general ward nursing leader (graduate in nursing) will be different from the intensive care nurse specialist and both will be different from the nurse in the outpatient clinic. The nurse in public health has drifted away even more from the general trend of the technological nurse specialists and I can see the day when these nurses will try to separate themselves from the main corps of nurses.

I suggest, therefore, that the academization of nursing opens many paths for the development of a new breed of ambitious technocratic nurses. But it creates a severe vacuum in many areas which traditionally belong to nursing and tomorrow will be going to new health professions. These developments are bound to create polarization and tensions within the nursing profession (such as we observe in medicine!) and the challenge facing the nursing profession is to cope with these trends and developments. I believe the chance that nurses will assume the responsibility of physicians in regards to clinical work are negligible but the dangers to the nursing profession are very real.

My question to the nurses is, are you ready for this challenge [3]?

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