Nursing ethics in an age of controversy

Nursing ethics is examined within the context of the health care controversy concerning care *v* cure. Yarling and McElmurry's contention[1] that nursing ethics should focus on autonomy and reform is critically appraised. In opposition, the moral sense of nursing practice is affirmed as the primary focus of nursing ethics. Reform concerns enhancing excellence in nursing within an expanding legitimate authority. The "in-between" situation of nurses is regarded as an excellent position from which to foster communal decisions by teams of health care workers engaged in the moral practice of fostering the well-being of the ill.

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AN ETHIC FOR NURSES must concern foundational issues in health care that give direction to policy formation. A current major controversy concerning the very nature of health care practice itself will affect the future direction of all health care policy and practice. The controversy focuses on whether health care primarily concerns cure or care as far as policy and practice are concerned. But as the authors have shown elsewhere,[2,3] it is rooted in underlying philosophical issues, some of which are very important in ethics.

CARE VERSUS CURE

Some interpreters of health care claim that health care is aimed at cure and that it will continue to become an applied science, a technology of medical science. They begrudgingly admit that present limitations in medical science require the continuation of the archaic view of practice as care, but eventually as medical science

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advances, care will be abandoned. Such a view of health care places nurses in an ambiguous situation because nursing traditionally has been identified with care. As medical science advances, will nurses become medical technicians, assistants to physicians in curing patients, or specialists in a type of care required to support curing? If nurses become specialists, this will require that they establish an area of expertise that they can direct autonomously. Since establishing an area of expertise will put nurses in competition with other health care professionals, nurses will have to reform health care policy and practice.

Opponents of this view contend that health care concerns practices used to care for the ill.[4-8] The two primary practices are medicine and nursing, which must work together to promote the physical and psychological well-being of patients. These practices have been altered by progress in medical science, but the advances have merely enhanced practice without changing its essential caring nature. Practice has also been changed by advances in the nursing profession, by increased power of hospital bureaucrats, and especially by the expansion of the patient's right to self-direction. Advocates of this position stress the need for a team approach to caring in which the nurse, while having specialized expertise, will continue as the "in-between" person responsible for day-to-day care.

ETHICAL IMPLICATIONS OF THE CARE APPROACH

This article develops the implication for nursing ethics of the latter, traditional view of the nurse by contrasting it with a nursing ethic founded on the idea that nursing is or ought to be an autonomous and, consequently, a specialized profession. Such a position has been argued by Yarling and McElmurry.[1] It is difficult to know whether they favor the curing approach to health care because, unfortunately, they do not give the health care context necessary for adequate understanding of the full implications of their nursing ethic. However, their approach to nursing ethics would suit the curing model of health care practice because it advocates autonomy in a specified area of expertise for nurses.

Yarling and McElmurry argue that nurses "are not free to be moral because they are deprived of the free exercise of moral agency."[1(p63)] They define moral agency as autonomy when facing moral dilemmas. They further state that in order "to be free to be moral" there are two necessary conditions: "(1) the emergence of a strong sense of professional autonomy and (2) a shift in the locus of accountability from the physician to the patient."[1(p66)] They also contend that nurses should focus on reform of the health care system rather than on individual morality so that the above conditions are met.

Yarling and McElmurry's arguments sound convincing because they develop them within the context of traditional philosophical moral decision making. Their position will appeal to many who, like the authors, support their contention that nurses need more autonomy, greater accountability to patients, and more involvement in the reform of health care.

In our desire for nursing autonomy, however, we cannot ignore the moral sense already present in nursing, the opportuni-

ties to reform health care from within, and the privileged in-between position of nurses in reaching moral decisions. The position taken by Yarling and McElmurry tends to denigrate the moral contributions made by nurses in their everyday work and blinds them to moral actions and reforms that can be made within the legitimate authority that nurses now possess or can acquire without the drastic reform of health care needed to give them full autonomy.

THE MORAL SENSE

The major sense of nursing is the moral sense of practice that tries to foster physical and psychological well-being of patients. Any discussion of ethics in nursing must begin with this experiential base of nursing practice. But, rather than beginning with the lived moral sense of nursing, Yarling and McElmurry begin with academic moral decision making as it is taught in typical ethics courses. Ethicists have traditionally argued that one acts morally by bringing one's actions under the control of a moral norm that defines the good. Some traditional norms are bringing about psychic harmony (Plato), fostering self-realization (Aristotle), acting on duty (Kant), acting out of love (Kierkegaard), and giving pleasure and preventing pain (Mill). To act in accordance with a moral norm, one needs autonomy. Therefore, autonomy becomes a necessary condition for acting morally. Thus, Yarling and McElmurry conclude that nurses lack sufficient autonomy to be moral agents. To support their position, they usually choose examples in which the nurse acts on behalf of the patient in tension or conflict with physicians or hospital bureaucrats.[1(pp68-70)] Since in these examples nurses obviously lack autonomy, Yarling and McElmurry contend that nurses can truly be moral agents only when the health care system has been reformed so that nurses can act as autonomous individual professionals. In fact, they contend that nurses need to be less concerned with traditional personal ethics and more focused on reform of the system.

Routine versus unusual circumstances

Yarling and McElmurry, like many in modern medical ethics, especially bioethics, stress structural and conceptual moral issues to the neglect of the moral issues in everyday practice. This is very unfortunate in professions that have a foundational moral sense, such as nursing. Since nursing practice aims at the well-being of the patient, the first moral responsibility of any nurse is excellent practice. Rather than beginning with the everyday moral responsibilities of the nurse to the patient, Yarling and McElmurry focus on situations that require heroic action by the nurse against the establishment. They believe that nurses should reform the system so that individual heroic action is not necessary for nurses to be moral agents. But what of the night nurses with too many patients, too few resources, and too

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little support who stay in there and do an excellent but routine job? Are they not to be called moral because they do not have the type of autonomy that Yarling and McElmurry find a necessary condition for morality? Would these nurses not be considered moral if, under such trying conditions, they were pleasant and gave personal support to a confused, dying patient? Benner would call the above the work-role competency of "coping with staff shortages [by] maintaining a caring attitude toward patients even in the absence of close and frequent contact."[3(pp151-153)] This is one of the 31 competencies Benner discovered in her excellent study of nursing practice. These competencies are primarily descriptions of how nurses fulfill the moral sense of nursing. Such moral action is now being taken by nurses without additional autonomy or reform of the health care system. According to Yarling and McElmurry, reform of the health care system is more morally significant than individual care for patients. Of course, nurses should seek reform that would change such conditions as those described above, but labeling excellent care as *merely* personal moral action misses the moral sense inherent in nursing practice.

Issues of individual freedom

Yarling and McElmurry place so much emphasis on wresting autonomy from hospital bureaucrats and physicians by reform movements that they neglect the autonomy inherent in the nature of the nursing profession. In exploring the nature of health care professions, Pellegrino[4] reminds us that professional means professing. The patient comes to the nurse or physician seeking help, and the nurse or physician professes to be able to offer that help. Pellegrino believes that professional means having not only the knowledge and the skill needed to help the patient but also commitment to and compassion for the patient. This means that most professional, moral autonomy grows from within rather than from reform of bureaucratic structure and rules that regulate professions. So to talk as if one cannot be moral without being given autonomy is to misdirect the major moral thrust of nursing.

Nurses do, in fact, understand that the moral sense permeates practice. In a study that the authors conducted with 80 nurses exploring fulfillment and nonfulfillment in nursing, they found that nurses felt most fulfilled when the moral sense of their practice became evident to them through an experience with a particular patient.[2] They most often felt least fulfilled when patients would not cooperate in their own treatment, were abusive, and demanded unreasonable and unprofessional services. This would pose a dilemma for Yarling and McElmurry because they believe a primary moral responsibility of the nurse is to be the patient's advocate against the establishment, ie, hospital bureaucrats and physicians. In this study, most nurses felt moral tension not in advocating for the patient against the establishment but when the demands made by patients conflicted with the legitimate authority of the nurse as a professional. Indeed, one could argue that one of the primary moral obligations of a nurse is to sustain excellent practice in the face of unreasonable demands and lack of appreciation on the part of patients. If nurses were hired by patients directly, as Yarling and McElmurry recommend, then

the patient could fire them for not acceding to their demands, hardly a condition to encourage a strong sense of professional autonomy.

Institutions afford security, stable financial support, facilities, and resources to their members. If one receives these benefits, then one usually pays a price—often loss of some individual freedom. As Socrates pointed out long ago, for a person to be free to make autonomous moral criticism and judgment, he (or she) must remain a private citizen. In fact, Socrates went so far as to suggest that such a person should not be paid. If one accepts the protection, salaries, and facilities of an institution, then one sacrifices some autonomy. If the institution is a just one, then that sacrifice should not involve legitimate authority to make decisions.

REFORM FROM WITHIN: LEGITIMATE AUTHORITY VERSUS AUTONOMY

The question of legitimate authority is certainly begged by Yarling and McElmurry in contending that because of "nursing commitment to patients and autonomy' in the exercise of that commitment . . . few nurses graduating from basic nursing education programs in the past ten years think they owe physicians anything other than professional excellence in practice."[1(p67)] Some professional excellence certainly requires that nurses carry out the treatment regimen as prescribed by physicians when they are within their legitimate authority to prescribe medications and treatments. Nurses generally faithfully follow such regimens because they value the well-being of the patient more than their own autonomy. Of course, Yarling and McElmurry, with their stress on autonomy "in the face of the enemy," discuss only cases in which the nurse recognizes that the physician is giving questionable treatment.[1(pp68-70)] They rightly point out that the nurse is in a precarious position when his or her moral sense calls for whistle blowing, especially concerning a physician. However, the tone of their article suggests that nurses are somehow alone in this dilemma. Not only do workers in industries, government, and private agencies face the same moral dilemma, physicians also do. Anyone who knows the "subculture of the health care professions"[1(p67)] recognizes that physicians cannot blow the whistle on each other without impunity. The point is certainly not that physicians are in the same precarious position as nurses but that the moral dilemma of whistle blowing is inherent in working within any social institution. Although Yarling and McElmurry demonstrate the individual side of this dilemma quite well, they do not discuss the fact that social institutions, in order to be effective, must maintain the trust of the public and harmonious working relationships between the various participants. But more importantly, institutions must protect the legitimate authority of practitioners, not only from other practitioners but also from patients and clients. Certainly nurses should not be unquestionably submissive

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to physicians and hospital bureaucrats. In fact, our sympathies are generally on the side of the "angels" (nurses, patients, and rebels), but, unlike the authors, we must grudgingly admit that the "devils" (physicians, hospital bureaucrats, and defenders of the establishment) have legitimate authority that must be worked with and through if the patient's good is to be promoted.

Being on the side of the "angels," however, should not commit one to what John Dewey called the "devil theory" of history. He claimed that people looked for some devil they could defeat to right the wrongs of the world rather than to face their own problems and attempt to resolve them. The devils in Yarling and McElmurry's article seem to be physicians, bureaucrats, and some nefarious institution called the hospital, which thwart the nurses' autonomy to do good on behalf of patients who want nothing but good done. They never question the good intentions of nurses, even when reprimanding them for being concerned primarily with personal morality and not with social reform. Presumably, if they were given autonomy, they, unlike physicians and hospital bureaucrats, would use it *solely* for the good of the patient.

Physicians and hospital bureaucrats have the same moral commitment as nurses in that they are there to promote the physical and psychological well-being of the patient. This means that when they exercise their legitimate authority to promote patient well-being, they are engaging in a moral good. This becomes evident when contrasted with a vocation that has no such moral sense, such as those businesses where the "bottom line" governs practices. Indeed, one worry in the health care professions is that the new for-profit hospitals will be governed by a bottom-line logic and that diagnosis related groups will make the bottom line the foremost concern of all hospitals. Of course, even in some nonprofit hospitals, some hospital bureaucrats and physicians put profit, professional well-being, and ego building ahead of the moral imperative of their profession; but then, so do some nurses.

Of course, nurses do not have the authority to make the same decisions that physicians and administrators have, but nurses have their own particular kind of authority. Nurses have the authority and power that comes from the control of the day-to-day care of the patient. After all, it was this control that made the patients in *One Flew Over the Cuckoo's Nest* label the Big Nurse as "big" in comparison to others on the staff of the hospital; including the physicians.[10] A positive example of the use of this power to expand legitimate authority occurred when nurses in one hospital over time effected a program instructing patients on how to care for themselves after discharge. Although this program was within the nurse's legal authority, some physicians were reluctant to "allow" nurses to teach patients about their diseases and their care after discharge because they doubted the nurses' ability to give correct information. As a result of compromise the nurses were able to do limited teaching at first, but over time they expanded the program until they were teaching what they originally requested. This change was not brought about by a prior sweeping reform that allowed the nurses to assert complete autonomy but by compromise and change that gradually occurred through those who controlled the day-

to-day practice. In other words, policy is changed not only in the way that Yarling and McElmurry advocate but also by the gradual change of practice that then becomes hospital policy. Certainly nurses should seek reform that would allow them to exercise their legitimate authority, but in the meantime they have a moral responsibility to change policy by changing practice in desirable ways. Furthermore, the change of practice, as in the above case, usually convinces those in power that nurses have the competence on which such authority is based. Professional autonomy can come from competence duly recognized by others.

IN-BETWEEN MORAL DECISIONS

Exercising legitimate authority to foster the patient's well-being seems to us to make more sense than talking about autonomy. The primary concern of health care professionals ought to be the well-being of the patient and not the practitioner's autonomy. Nurses need to be able to exert rightful authority in order to use their competencies to promote the patient's well-being. But nurses generally promote the patient's well-being by working together with other health care professionals. An excessive concern for autonomy can put health care workers in conflict with each other. In contrast, recognition of each health care worker's rightful authority, competencies, and contributions promotes the harmony necessary for team care. Engelhardt[7] points out that team care should recognize individual, as well as professional, competencies. For example, following Englehardt's suggestion, if the nurse on the health care team were more competent in diagnosing a certain kind of disease than the physician, then individual competency rather than professional designation would determine who would make such a diagnosis. Regardless of the practicality of this suggestion, it is important to recognize that it is based on the exercise of competencies within the team rather than on individual or professional autonomy. Furthermore, it carries to its logical conclusion the growing tendency for health care professionals with different competencies to work together as a team.

Team approach to decision making

Cooperative teamwork is difficult when members of the team are primarily concerned with their own autonomy. Such teamwork is fostered by what Habemas has called dialogue without domination and communicative action.[11] In contrast to the autonomous approach to moral decisions, the team approach holds that physicians, nurses, patients, and sometimes others in the hospital and family try to reach a decision together concerning the patient's well-being. It is doubtful that any of the above participants ought to act autonomously because all of their deliberations are needed for the decisions and actions fostering the well-being of the patient. While it is true that in the final analysis the patient has the legal right to decide, in actual practice such decisions are usually cooperative because each party has different competencies and legitimate authority to contribute to decisions concerning treatment and care.

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privileged position. Englehardt[7] pointed out that nurses are the persons in between in health care. By this he meant that they are caught between the traditional authority of the physician, the emerging rights of the patient, and the growing power of hospital bureacrats. Being caught between these various factions makes it difficult for nurses to make decisions without taking into account the roles, rights, and possible responses of physicians, patients, or hospital administration. However, the in-between place of nurses, rather than freeing them from the responsibility of moral decision making, makes their contributions to moral decisions more important than if they could act autonomously. Nurses, because of their in-between situation, should bring to consciousness the in-between nature of moral decision making by health care teams and teach others on the team whose pretensions to autonomy have kept them from learning to engage in dialogue without domination and in communicative action.

Dual perspective on in-between decisions

In-between moral decisions have two senses. The first sense indicates that moral decisions in health care practice are cooperative decisions, involving patient, physician, nurse, and often hospital administration or policy. The other sense involves deciding from an in-between position. The nurse shares with the physician, patient, and hospital administration the moral responsibility of reaching communal decisions concerning health care, but unlike the others, nurses work from a unique in-between stance.

One sense of in-between moral decisions results from health care being a cooperative enterprise. Moral decisions within this enterprise require cooperation and accommodation among those involved. The primary actors in the situation are patients, physicians, nurses, and hospital bureaucrats, each of whom has special rights and privileges secured by law, custom, or the requirements of the situation. Thus, moral decisions concerning health care are of necessity in-between decisions. Those who contribute to these decisions do so from different vantage points. When these perspectives function as they should, they contribute to the moral sense by fostering the well-being of the patient. However, when the technical-occupational sense replaces the moral sense, the well-being of the patient is no longer the primary goal of the health care. For example, when an administrator is locked into a technical-occupational outlook, the bottom line or the rules and procedures of the institution are often placed above providing a good setting for health care. Likewise, the physician can place the prestige of the medical profession above the care of his or her patient, as can the nurse or the technician. When this happens, the technical-occupational sense is placed first, and the moral sense no longer calls the various participants to contribute their professional understanding and skill to decisions that promote the well-being of the patient.

The second sense of in-between moral

decisions concerns working from a position in between the patient, the physician, and the hospital bureaucrat, as nurses have traditionally done. The nurse must carry out certain orders and prescriptions of the physician, is usually closest to the patient in terms of knowing needs and receiving requests, and often is responsible for maintaining order and hospital policy. Thus, any moral decisions nurses make concerning the well-being of the patient must take all of these factors into consideration.

Does the unique in-between ambiguous situation cast the nurse in the role of a facilitator of moral decisions rather than as a maker of them in cooperation with others? If being a moral agent means making judgments from moral principles as traditional ethicists have argued, then the nurse's logical role would be that of fostering compromise. But what is called compromise by traditional ethical theorists becomes fostering decisions that promote the physical and psychological well-being of patients when viewed from the moral sense of health care. After all, the health care context requires that decisions concerning health care be made cooperatively by the physician, patient, and nurse working in a setting conducive to good health care. To this cooperative decision the physician contributes professional knowledge and skills, the patient brings the desire for and understanding of a good life, and the hospital administrator provides facilities, equipment, and social organization. What does the nurse bring? Do nurses simply adjudicate between physicians, patients and hospital administration? Not if they follow the moral sense that requires cooperative decisions for the good of the patient. The special in-between position places nurses where they can better contend for the needed cooperation because they share the medical side of the decision with the physician, the hospital policy side with hospital administration, and the personal side with the patient. Thus, the nurse is in a more privileged position for fostering the communal decisions that the moral sense requires. In short, the nurse, rather than being a facilitator of compromise, is an advocate of communal decisions that bring together expert medical advice and treatment, sound hospital policy and procedure, and the realizable hopes and aspirations of the patient into the concrete practice of health care that fosters the well-being of the patient.

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During a time of confusion and controversy, not only concerning health care practice but also the very nature of health care itself, it is tempting for nurses to find an area of expertise into which they can retreat and reign supreme. This article's purpose has not been to argue against defining nursing as a special area of competency in which nurses excel, such as Benner[9] has done in her fine study of excellence from within nursing practice. Indeed, like Benner, we believe that any study of nursing should begin with practice. In the case of nursing ethics, this means beginning with the moral sense of nursing rather than with ethical theory. When one begins with the moral sense, Benner's competencies give concrete direction to nurses in fulfilling the moral sense of practice. Such excellent practice is not to be depreciated as mere individual mo-

rality but should be regarded as exemplifying the moral sense embedded in nursing practice.

The reform of nursing, therefore, primarily concerns developing greater excellence in nursing practice within an expanding area of legitimate authority rather than wresting autonomy from some alleged establishment. Indeed, the focal question in nursing ethics is not autonomy but the promotion of the well-being of patients through communal decisions aimed at better patient care. When viewed from this moral sense, the in-between situation of nurses, which is such an offense to those who want autonomy, becomes a privileged position for coming to concrete decisions within a team setting. This approach affirms the traditional view of nursing as care and suggests that all health care is essentially what the name implies—the moral practice of caring for persons who need help restoring, maintaining, and promoting good health.

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