

# CHAPTER 6

## DEFINING NURSING ETHICS APART FROM MEDICAL ETHICS

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[Nursing is concerned with health while medicine focuses on cure. There is a functional difference also in care and healing. The political distinction between nursing ethics and medical ethics is stronger yet. Still none of these alone distinguish the two approaches. Nurses need preparation for the reflective thinking of ethics with or without a difference between medicine and nursing.]

A dean of a major nursing school recently said . . . , “We’re not interested in *medical* ethics; there is virtually nothing there that is pertinent to nursing. Nursing has its own issues, problems, and principles, and they’re quite different from, and often opposed to, those of medicine.” She might well have gone on to point out that nursing also has its established codes of ethics and doesn’t need a philosopher (especially one who has taught medical ethics), to tell it what is right and wrong, good and bad—but she kindly refrained from that step.

Her comment set me to thinking about the proposition that there is a distinct body of problems, issues and principles for the profession. It seems to me there might be three general arguments to be given in support of this claim, apart from a detailed, nitty-gritty examination of the many facets and dimensions of nursing practice. I shall call these the argument from historical tradition, the functional argument and the political argument.

### A. HISTORY

The argument from historical tradition might begin by pointing to Florence Nightingale’s 1893 paper. Since then nursing has ascribed to

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the ideals of treating persons rather than diseases. Prevention is better than cure.

Hospitalization has definite limits in its ability to promote "positive health." The history of nursing is a history of nurses' struggles to adhere to these ideals through fostering the patient's active role in treatment and prevention through educational movements, home health care and improved personal hygiene and food handling, and through working for improved hospital conditions to reflect better the psycho-social aspects of illness. By contrast, medicine has opted for an approach that emphasizes curing as a response to the occurrence of disease, a paternalistic approach to medical decision making, and the hospital as the locus of the best medicine.

One might summarize the difference by saying that nursing has conceived itself as a health oriented profession. It emphasizes the preservation and restoration of health to persons. Medicine has conceived of itself as an illness oriented profession. It emphasizes the treatment and prevention of disease, injury and deformity through sophisticated surgical, bio-chemical and technological interventions. Further, nursing has a major preoccupation to compassionately aid individuals to adapt to chronic illness and diminished capacity. Medicine has a major preoccupation with defeating the conditions that make for such diminished lives and capacities. Given such radically different orientations of history and traditions, the argument concludes, it is to be expected that nursing and medicine will have radically different values and ethics.

While there are indeed important differences between some aspects of nursing's and medicine's history, there are some major flaws in the argument from historical tradition. First, a history is always selective and is conceived usually under the guidance of preconceived ideas about the movements and factors one wants to validate historically. Any history is an interpretation which necessarily ignores or discounts as insignificant more than it records.

The foregoing argument ignores the close ties between the ideals and aims of nursing and medicine that have been commonplace for decades before and since Nightingale. It ignores the preventive and wholistic movements in medicine. It ignores the specialization and compartmentalization in nursing against which the total patient care movement was a reaction. But most importantly, a historical argument does not establish anything but a description of (some) past practices and patterns. In and of itself, it does not establish any authority for their preference and continuation at the present. The description may be accurate. It does not form a sound basis for the generalization that there are and should remain important differences between nursing and medical ethics.

## B. FUNCTION

By contrast, the functional argument proceeds from a description of present nursing practices and a theoretical account of what nursing should be ideally. The actual details of the history of nursing and medicine may not demonstrate the divergence of their ethics and values. If one looks at function and if one subsumes present practice under nursing theory, one can see the difference that supports a different ethic.

For example, in contemporary practice, the typical physician interaction with a patient is brief. It is to get a medical history, symptoms and signs, consent to a proposed intervention, or compliance. All this serves the goal of cure. The physician reviews examination and test results, arrives at a diagnosis and therapeutic regimen. S/he writes orders, supervises specialists in administering therapeutic procedures, and checks on the patient's progress. By contrast, the nurse's interaction with patients is much more extensive and personal. It focuses on the patient's values and perceptions and adaptive/restorative processes. Nurses may have been co-opted as physician's assistants. Yet nursing ideally functions not as an extension of the physician but as a complement.

A root metaphor is sometimes used, although its sexist overtones make it unfashionable among more politically minded nurses. Nursing has affinities with the maternal functions of nurturing, education and caring for the young. The term derives from the Latin "nutrio" meaning to nurture. Thus nursing is like ideal mothering. It fosters education, growth and protection of those in child like states where they are unable to provide for their own nurture. Medicine, by contrast, is not focused on nurture of health, but on combat with the enemies of health—disease, malfunction and injury. The root Latin here is "medicus," healing or making whole again. The language of medicine reveals the process is thought of in warlike terms: combat, struggle, defeat, fighting are commonplace. The functional understanding of medicine is struggle against an enemy. The nurse and the physician are primitive mother and father, nurturing children and protecting them from the enemy. The functional argument concludes the ethics are different. Compassion and support are fundamental virtues in nursing. Courage, authority and risk taking are those of medicine.

Important as these functions are, to insist that they are specially tied to nursing and medicine is to caricaturize, not characterize, these professions. The recognition of the essential integration of healing and nurture has waxed and waned periodically in medicine and nursing both. But in the ideal functioning of those arts, they are inseparable. The recurrent interest in wholistic medicine, preventive medicine and

family practice, public sanitation, diet therapy and psychosomatic medicine are all responses of medical professionals. They perceive that the best medicine integrates nutritive and disease combative functions rather than treating them as independent and inseparable. Nursing is moving towards informing and improving its functions with more formal training. It is increasingly active in history taking, physical examination, diagnosis, and technical therapy. Specializations are emerging like anesthesiology, intensive care and pediatric practitioners. This points to a recognition that there is an essential connection between the supportive and diagnostic/therapeutic modes of involvement with patients.

Thus, the most that the functional argument can hope to establish is that there is a difference in emphasis in nursing and medicine. But that reflects more a division of labor from specialization of training than divergences in fundamental underlying processes and concerns of the professions. Certainly one cannot point to the ideal of each profession and say, "Here are clear differences that must manifest themselves in different ethics." Both professions share a commitment to the health and well-being of individuals. There is a commitment to defeat disease, to marshal all the person's psycho-social resources, as well as physiology, to use modern medicine in defense and comfort of the ill and infirm. Here are grounds for mutual ethical commitments by both professions, rather than a different ethic.

I will return to this line of argument shortly. It is first desirable, however, to consider the political argument for the view that nursing and medicine have different ethics.

### C. POLITICS

This turns on a class or economic struggle between nursing and medicine. Those engaged in the struggle, see nursing as having served too long in medicine's shadow. They believe that nurses have inadequate working conditions, pay and public respect. For nurses to get these, nursing must be defined as an independent profession. It must get away from the maid servant image. Nursing must organize and even unionize to get economic leverage and the power to dictate better working conditions. Such developments as independent nurse practitioners must be encouraged to gain public respect. So nursing must be defined as independent. That includes the area of ethics. Nursing ethics ought to be articulated to reinforce nursing's independence of the profession of medicine.

Functional differences do not serve the purpose. The nurturing, maternal figure does not accord with economic independence and enhanced

status. That tradition has reinforced the subservient posture. Attention to language also means new terms so that patients become clients. There is a conscious effort to avoid sexism—feminine pronouns for nurses and masculine for physicians. There is a national movement to the baccalaureate degree for nursing. Doctoral programs have been designed in nursing as opposed to the traditional routes for doctorates in education and communication.

I am ambivalent toward the political argument. Nurses have received the short end of the economic stick. They have not been given public respect and the status they deserve. They have been exploited in work. At the same time, I find it alarming as a consumer of health services, that the conclusion is drawn so easily that nursing ethics is different from medical ethics.

To say that nursing ethics is wholly different from medical ethics would imply that the principles of conduct, moral aims and obligations of nurses and physicians differ even in the same sets of circumstances. Further, it would imply that those professionals would be under no positive obligation to coordinate their actions [unless their ethics called for coordination as in the ANA Code for Nurses]. One ethic might dictate the patient be told the exact nature of the illness while the other said no. Both could not be done. The outcome would lie with whichever professional had the clout to dominate.

Finally, on this political basis, one could justify a separate ethic for any health care profession—physical therapists, hospital administrators, etc. Any group would have a right to define an independent ethics. Nor would nursing itself be assured of unity. Nurse anesthetists function differently from nurse practitioners and may have differing political needs. LPN's and LVN's might find it politically expedient to organize in contradistinction to RN's. Each of these political facts and functional differences could, if the earlier lines of argument held, result in a separate set of ethical commitments [unless, again, the ethics called for coordination].

The proponent of the political argument could say reality means compromise on differences. This could mean developing a consistent inter-professional set of ethical principles. Politics sees money as basic. Politics is the art of the possible. So the give and take of the bargaining table might well be the proper method for resolving differences. Such bargaining would not ensure the best interests of the consumer. So the consumer might be a party to such negotiations.

There are other concerns. Without a set of common assumptions and commitments as a basis for resolving issues, the resolution may be based on political and economic power. Nurses will lose—particularly with the

medical profession actively creating new health professionals who are taking over nursing functions while staying under more direct control by physicians. (That's a political argument against the political argument!)

Moreover, there is a deep-rooted relativism underlying the political argument which at bottom is absurd. How can it be sensible to say that what a patient has a right to differs according to whether a physician or nurse is involved? A physician is obligated to get informed consent before proceeding with a risky invasive procedure. How could it make sense that the nurse who administers it is not under an obligation to stop if the patient does not understand? How can it make sense to say a physician can refuse to do an abortion but the nurse can't? A particular level of education may determine professional privileges but not moral rights and duties. If it did, it would be moral elitism that flies in the face of universal moral rights and obligations.

How effective the foregoing argument is against the view that there is an independent nursing ethics, I cannot judge. It is quite possible that nursing, or substantial factions within it, will remained committed to a political approach. But perhaps it would be worth while to explore a set of common ethical principles for a common basis for new relationships with medicine.

But there are still questions if such an inquiry is needed and who will make it? At the beginning I mentioned another line of objection that might be taken to the intrusion of a philosopher in nursing ethics. This hints at a number of points which need to be laid out more fully.

Nursing has several codes of ethics: The International Council of Nurses' "Code for Nurses" (rev. 1973), the American Nurses' Association "Code for Nurses with Interpretive Statements" (rev. 1976; Statements rev. 1985), various other countries and provinces and some nursing specialties. Nurses who take the Florence Nightingale Pledge ascribe to a set of ethical ideals there as well. Finally, specific institutions have their own rules and standards of conduct. Nurses do not lack ethical standards. Do they need anything more?

Skill in applying such rules requires reflection. What are the options? Who decides? How is the decision made? A code gives guidance but it may be ambiguous. Rules may conflict as in research. A nurse contributes to the profession's body of knowledge by research. However, a research protocol may require a placebo as a control and that may include deception. To decide which rule to follow and which to violate, the nurse must appeal to a broader set of principles. That may mean setting priorities.

No code has ever covered all ethical dilemmas. The view that all a nurse needs is a code, is oblivious to this [and does not understand the

nature of the code]. The unwary may believe they do not have to grapple with decision making that involves more than applying a rule. Finally, while a great deal of careful thought went into the codes, that very fact indicates they are not immune to criticism or improvement. Technology has increased our choices. Nurses are taking increased responsibility and independence. The professions will be better served by active critical discussion to improve the codes than to pretend they are beyond changing. (This is not to say there are no timeless ethical truths. Rather, particular statements of them may be relative.)

The other part of the criticism referred to earlier involves an alleged breach of professional integrity. The argument may go like this: unless also qualified as a nurse, a philosopher has no business being critically involved in discussions of nursing. Everyone has had bad experiences with busybodies, moral do-gooders who charge in to set aright situations where their arrogance is exceeded only by their ignorance. The non-nurse ethicist is in grave danger of being just such a busybody.

This is an ironical view since nursing has many criticisms of medicine, etc. There are, of course, important differences since nurses know medical procedures while a non-nurse philosopher does not. Beyond additional training, perhaps the philosopher can only point to the results and wear the scarlet letter when the title of busybody has been earned. But there is additional justification for critical examination.

Philosophical training helps one wear different hats to generate the best possible reasons for conflicting views. A philosopher should be able to present systematically, sympathetically and forcefully the viewpoints of others in a dispute. It may be difficult to pin a philosopher down on his/her personal convictions. Steve Martin, the comedian, calls this a kind of permanent confusion from the study of philosophy. More important, it is the conviction that fairminded, intelligent people can disagree on pretty fundamental issues. Such disagreements are less the result of personal stubbornness than differences in traditions and culture. It takes time and reflection to see the bases of such disagreements, and possibly to resolve them. This is especially true in ethics where questions have been called perennial and where concepts have been said to be essentially arguable.

The philosopher has acquired some comfort in dealing with these questions and concepts. On this basis, s/he can discuss them with other professionals, rather than speaking as a true believer out to reform the world. A dilemma may disappear when looked at carefully. Sometimes a decision made elsewhere will already have answered a troublesome question in a new area. Sometimes an issue involves a very basic choice between competing principles. One's very foundations may be shaken

and reformed by that choice. Should any of these experiences occur, the discussion will be considered worthwhile.

### FOR FURTHER READING

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