16 Report

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About the cover: Head nurse, Linda Lundgren, R.N., discusses her experiences in Emergency Department at St. Francis Hospital and Medical Center. Linda, a graduate of Stormont-Vail School of Nursing, tells why she chose emergency department nursing instead of another area.
To be, or not to be: that is the question. Whether 'tis nobler in the mind to suffer the slings and arrows of outrageous fortune, or to take up arms against a sea of troubles and by opposing, end them? . . . To die, to sleep; to sleep? perchance to dream. Ay, there's the rub ..." Hamlet's soliloquy can be understood both as expressing the Prince of Denmark's struggle with the temptation of suicide and also as an expression of his sense that he ought to oppose and expose his uncle (who has killed his father and married his mother), but lacks the courage to do so.

Shakespeare's Hamlet, like many nurses today, was faced with a situation in which others had violated the dictates of law, morality and decency, and in which he was subject to the authority of those against whom he was a potential witness. The nurse, like Hamlet, struggles with conscience in debating whether to blow the whistle on instances of professional incompetence or misconduct or to whistle at them as though they are none of the nurse's concern. And, like Hamlet, the nurse must decide whether to suffer silently and have sleep spoiled, or to speak out and risk retribution and dismissal.

This essay seeks to identify arguments that can be offered for and against a duty to actively oppose what one believes to be incompetent, illegal or unethical acts, whether in one's nursing peers, superiors, or members of other professions including medicine and administration. It also seeks to assess the new commitment of the nurse, through the ANA Code for Nurses, to an activist stand on the question, and to indicate the sorts of steps that may need to be taken to ensure that that commitment does not place an undue burden upon the nurse. As we shall see, the issue is not just one of courage; it cuts deeply into the very fabric of the nurse's professional relations to clients and their families, to physicians, to other professionals and paraprofessionals and to society.

The traditional view of the locus of responsibility for patient care is that it lies with the attending physician. This view turns on several alleged facts: (1) The physician is the person who proposes therapeutic measures to the patient; the latter gives the physician the permission to carry out those measures. Hence, the primary relationship whereby anyone is authorized to provide the patient treatment and care is the patient/physician relationship. It should be recognized that community health nurses and nurse practitioners may represent exceptions to this; nonetheless, it is the dominant form of interactions with the medical team, and where physicians are involved, it almost always will be perceived, especially by patients and their families, as the operative form. (2) The physician delegates that patient-given authority to others on the basis of the physician's case-management decisions. This delegation may be made through the specific orders of the physician, or through the route of the nurse's knowledge and skill meeting professional and legal standards of nursing practice and the physician's reasonable belief that qualified nurses will adhere to those standards in their practice. (3) The physician thus employs nurses, aides and other allied health personnel in the pursuit of the goals of medical and health care decided on by the physician and patient. These individuals are employed either directly (as with office nurses or surgical aides) or indirectly (as through the use of hospital-employed personnel by the physician with hospital privileges). (4) Finally, the physician carries the risks of malpractice litigation, bears the costs of malpractice insurance, and suffers the losses of prestige and public acceptance in the case of a malpractice action; the theory is that the physician is liable for tort damages to the patient both because he is either the direct cause of injury or in control of those who are, and because he is best able to bear the costs and to spread them among his other patients as part of his overhead. Given this cluster of factors, so the traditional view goes, the appropriate relationship of nurse to physician is something very much like the relationship of employee to employer: bound by a duty of loyalty to secrecy regarding matters of potential embarrassment and damage to the physician; relieved of liability and legal responsibility for physician-originating decisions and actions that may harm a patient (and even from civil liability for personal mistakes); and standing in no independent relationship with the patient in which judgements about disclosure, risk information and direction of therapy can be made apart from the orders of the physician, except when authority to do so is delegated by the latter.

This traditional view, however self-serving to the interests of the physician it may seem, has not been without its acceptance in nursing. Various nursing texts written during the first half of this century emphasized the importance of etiquette (understood as involving never overstepping one's bounds and presuming to correct, instruct or disagree with a physician), and of obedience and loyalty to the physician with absolute respect for his authority. One, in a fourth edition published in 1943, contained a chapter entitled "Master and Servant: Physician and Nurse", in which the view was stressed that "If the hospital employs the nurse then she is a servant of the hospital and as such the hospital becomes responsible for her acts. With this status any disobedience to the physician's orders is not only a matter of professional etiquette but a violation of the employee contract. In those situations where the nurse knows that the physician is mishandling the patient's treatment she must either continue to carry out his orders or give up the case. . . . [T]he nurse ought to remember that she has a duty of charity as a faithful servant to a master to protect the good name and reputation of the physician under whom she works." And the second edition of a nursing text pub.

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lished in 1955, in commenting approvingly on a physician's remark that "to be a suc-
cessful nurse, one must also be a suc-
cessful liar", noted both a contractual and a
professional duty to the physician to pro-
vide not only efficient care of patients but also "such evidence of loyalty as will
strength the patient's confidence in him." Even such a document (revolution-
ary in its time) as the Florence Nightingale Pledge, still repeated today by many a
nursing graduate, emphasizes the nurse's duties of obedience and loyalty to the
physician.

Changes in the nursing profession's
view of these matters that have occurred
since mid-century are of the greatest
historical significance. For, while profes-
sional nursing codes of the 1950's echoed
these earlier perceptions and admonish-
ments, they began to do so more com-
plexly and with reservations. The Interna-
tional Council of Nurses' 1953 Code of
Nursing Ethics, for example, juxtaposed
two duties which no doubt sounded con-
tradictory to the ear trained with those
earlier documents: "The nurse is under an
obligation to carry out the physician's
orders intelligently and loyally and to refuse
to participate in unethical procedures "
The duty to sustain confidence in the
physician is affirmed along with a similar
duty to other members of the health team,
but the nurse is enjoined to expose incom-
petence or unethical conduct of associates,
"but only to the proper authority." We may
assume that the proper authority did not
include the patient or the patient's family.

"The duty to sustain con-

(The continued from page 7)

Code of Nursing Ethics, in addition, has
dropped all references to carrying out
physician's orders and to a primary duty to
maintain the patient's confidence in the
physician, substituting for it a duty to sus-
tain a "cooperative relationship with co-
workers in nursing and other fields." Thus
within less than a 40-year period, the self-
centric conception of nursing, represented by texts and codes written by nurses for nurses,
have evolved from the passive view of the
nurse as an employee and instrument of
the physician, to that of an active profes-
sional relating to physicians and other pro-
fessionals as an independent practitioner.

Now it might seem that, while remark-
able, this petite revolution has little or no
broader significance than as an adjustment in
the nurse's role vis-a-vis the client (nee
patient) and the physician. However, when we
investigate the thought of others on professional relationships in general we
begin to see that the far-reaching and
revolutionary changes in this reconception of
nursing. In order to explore this theme, it
is necessary to turn to an apparently im-
probable source of insight, legal literature
on corporate business ethics.

In 1958 the American Bar Association
issued the Restatement (Second) of
Agency, a standard reference work which
digests the body of federal, state and
jurisdictional laws and precedent that defines
and governs the legal obligations of agents
(employees) to principals (employers). In
what follows, the reader may substitute the
terms "employee" and "employer" wherever
"agent" and "principal" occur; whether to
substitute "nurse" and "physician" or "hospital",
etc., is a question we will shortly
address explicitly.) The agent's duty to
obey the principal is stated in sections 383
and 385 of the Restatement. 385(1)
stresses that the agent has "a duty to obey
table all reasonable directions" of the principal,
and continues:"In determining whether or
not the orders of the principal to the agent
are reasonable . . . business or professional
ethics . . . are considered. In no event
would it be implied that an agent has a
duty to perform acts which . . . are illegal
or unethical . . ." Blumberg observes that
this doesn't authorize the agent to disclose
those orders or to refuse to comply with
an instruction by the principal not to
disclose any information about the prin-
cipal's affairs, "even in those cases where
his is privileged not to perform in accor-
dance with the principal's instructions."

And, while an agent may act contrary to
the orders of a principal in order to protect
his or her own economic interests or pro-
fessional reputation, "there is no suggestion
that an interest which he is privileged to
protect includes the public interest."

Other sections of the paragraph under-
score the duty of loyalty, meaning a duty of
the agent to the principal "to act solely
for the benefit of the principal in all mat-
ters connected with his agency", except in
protection of his own interests (economic
and professional). And, while an agent
may enjoy the privileges of citizenship and
campaign for legislation or other policy
changes that would not be supported by
the principal, he may not disclose informa-
tion about his principal which is entrusted
to him as an agent. The agent is explicitly
placed under a duty of confidentiality with
respect to information given to him con-
fidentally by the principal, and also with
respect to "information which the agent
should know his principal would not care
to have revealed to others." The exception
to this duty is the privilege (significantly,
not a duty) to reveal such confidential in-
formation if it "is to the effect that the prin-
cipal is committing or is about to commit a
crime . . ." Thus, while the agent is re-
served the privilege to refrain from obeying
the orders of the principal in case to obey
would be to commit an act which is either
criminal or unethical, the agent may "blow
the whistle" only on a criminal act; blowing
the whistle on an unethical act is not per-
mitted, unless that act is also criminal. It
is important to understand that there is a dif-
erence between criminal acts and acts for
which one might reasonably bring a civil
action in order to claim damages; under
the Restatement doctrines, one is per-
mitted to blow the whistle only in the
former sort of case. Finally, it is important
to note that these exceptions to the duties
of agency are generally ones of citizenship
which hold regardless of one's status as
employee.

The significance of applying this gen-
eral view of agency to nursing, particularly
in light of the changes in its self-
perception, is obvious. If we read the nurse
as the agent and the physician or hospital
(or nursing home, etc.) as the principal,
then the view of nursing which I have
called the traditional view seems to be the
 correct one. On that interpretation, nurses
as employees or agents have certain duties
arising from that status and those duties
are the duties of obedience and loyalty to the
principal, and of confidentiality with
respect to the physician's and hospital's af-
fairs, including the actions of the former in
regard to patients. The nurse would appear
to have only the following options under
the theory of Agency: the nurse is per-
mitted to refuse a physician's orders
without a breach of contract where to
comply with those orders would involve
committing a criminal or unethical act or
would involve a demonstrable risk to the
nurse's economic interests or professional
reputation; the nurse is permitted to
disclose information about the employer
which would otherwise be confidential only
when that information pertains to criminal
acts by the physician or other employees
of the hospital. Insofar as the new codes
do not reinforce these points but may urge
the nurse to regard as a duty what the
theory of agency identifies as only per-
missible, and may even require the nurse

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to violate certain duties of agency, the view of nursing they encourage and espouse represents a radical departure from the traditional views which dominated in the first half of the century and which formed the fundamental set of expectations of most physicians and nurses educated prior to the 1970’s. It also represents a radical departure from a much more widely shared, legally entrenched view of nurses in terms of employer/employee relations, in that nurses are asserted to have a set of duties that are contrary and contradictory to those which would govern their status as agents or employees.

Nor is this departure one which adversely affects the nurse’s role as employee; it may also have far-reaching consequences for the ethical character of the physician/patient relationship. Consider the following case, quoted from The New Yorker, of a young woman who had had an elective abortion: “I went into the hospital early in the morning, and was home in bed early that evening. At seven the next morning, the telephone rang.” A woman (said,) “I heard that yesterday morning you murdered a six-week-old baby girl, and we’d like to offer you some guidance.” I called my doctor, and he told me that anti-abortion groups pay nurses for lists of women who have had abortions, the same way diaper companies used to pay nurses for lists of women who had given birth.”

I am not interested in present purposes in whether this anecdote is true. It does represent an application of the new duty of the nurse, wherein the nurse is legitimized in her professional role as a keeper of the ethical interests of society—not as agreed to through some legal consensus, and not merely to the extent that she is permitted to refuse participation in activities which she regards as offensive non personal ethical ground—by a professional code which obligates her to act to safeguard the “safety” of the public as endangered by the “unethical practice” of any person, without saying what constitutes unethical practice. In short, revisions in the nursing codes have transformed the nurse from the role of an employee who is a citizen to that of a defender of an unspecified morality.

In order to move toward an appraisal of this new view of the nurse, it may be useful to consider some possible interpretations of what the nurse will be if realities approximate the vision of the Code. Is the nurse, like the physician, a principal who offers a service to the consumer? Is the nurse the patient’s advocate, charged with representing and defending the patient in matters involving potential and actual threats to the patient’s safety and health that originate in the actions of others? Is the nurse like a public employee or corporate employee who serves as a contact for a Ralph Nader or a Jack Anderson, an employee who occasionally breaches her duties to her employer in service of a higher public interest? Or is there some other understanding that can be achieved of the emerging role of the nurse?

The current Code can be viewed as depicting the nurse as a professional, backed by a developing body of knowledge, possessed of standardized training, guided by a code of conduct and admitted to practice by professional licensure or certification, who offers to the public a service known as nursing that may overlap with and compliment medical care but is not subspecies of it. To this point, the view of nurses as on a par with the physician is correct. Nonetheless, it does not entail that nurses are principals. That status is bestowed by virtue of a contractual relationship between consumer and the provider of the service. In the case of most medicine, that contract exists between patient and physician, where (in theory) the needs, mutual expectations, goals and understandings which are to govern the provision of that service are agreed upon by physician and patient alike. That this is not always so can be seen from the existence of physicians in the employ of corporations or insurance companies who are serving the interests of those principals as their agents and to whom the patient is required to go for examination or evaluation as a condition of employment or the issuance of a policy. No such negotiations occur between the nurse who is employed by the hospital or physician and the patient, except insofar as required by the physician’s case-management decisions. Hence, with the exceptions of nurses who are employed by the patient or who deliver to individuals nursing services without the mediation of a physician (as a community or public-health nurse or perhaps a nurse practitioner—and even in those cases there may be a nominal primary relationship with a physician), nurses are not in a relationship to the consumer that is comparable to that of the physician. With the possible exceptions just noted, nurses obtain their warrant to practice on the client through prior agreement of the patient and physician. Hence, it would seem that the nurse does not now qualify as a principal.

Moreover, it is not at all clear that it is in the patient’s interest to have nursing establish a pattern of professional identification which increases the number of individuals with whom the patient must negotiate to achieve a meeting of the minds. For, should that pattern be successful, what inherent reason is there to oppose similar self-declarations of dependence of other professionals who have direct contact with the patient? Shall the patient have to establish professional/client relations with the social worker, the physical therapist, the occupational therapist, even the x-ray technician and the hematology technician? Is each professional who enters into a therapeutic relationship with the patient to regard the latter as does the physician?

Finally, it is unclear to me whether it is in the nurse’s ultimate interest to move from the status of an agent to that of a principal. To do so without substantial alterations in medicine’s self-image is to court not a new relationship with medicine but no relationship at all. Physicians are apt to regard the creation of additional allied health professions as preferable to changing fundamentally their relationship with nurses, and the evidence for this already exists, perhaps, in the physician’s assistant training programs which are in rapid ascendency nationwide.

The second view of the new role of the nurse is one with a great deal of currency in present nursing literature. The nurse as patient’s advocate, according to the root meaning of the term, would be one who speaks in favor of the patient; but
the more common understanding of an advocate comes from a legal setting, where an advocate is one's lawyer or attorney, empowered in various ways to act on one's behalf and in one's stead in matters of a legal or quasi-legal sort, as well as serving as a counselor and advisor on business and personal matters. Anna's 33 has speculated on how patients' rights might be protected through the presence of a patient advocate within the hospital. Such an individual would be paid by health departments or third-party payers, as a condition necessary both to impartiality and to protection from retribution. This individual would serve as a mechanism for countering institutionalized tendencies to lose sight of patients' rights to self-determination, and would have access to all the patient's hospital records, the ability to call in consultants, an active role in patient care quality monitoring committees, the ability to lodge complaints directly with the top of the hospital's administrative hierarchy, the ability to delay discharges, and the ability (at the patient's request and instruction) to participate in discussions of the patient's case. It appears essential for such an individual to be employed independently of hospital or physician in order to be freed not only from coercion and bias, but also from the usual duties of agency. A nurse would thus not be able to serve as such an advocate and remain in the role of physician's or hospital's employee, administering nursing care at the direction and authorization of the physician. Hence, the justification of the new nursing role that characterizes the nurse as patient's advocate seems to require mixing of two roles, that, as presently structured, cannot be combined.

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The further difficulty with the advocacy interpretation is that it seems to require a separate and direct relationship between the patient and nurse whereby the former truly becomes the latter's client, just as the parties of a legal dispute each have their own advocates. The nurse, as presently employed in settings where physicians are the principals and the authorizers of care, does not stand in such a relationship to the patient that would warrant the patient being the nurse's client and the nurse the patient's advocate.

The insight that is emerging from the consideration of the interpretations of nurses as principals or as advocates is that for those characterizations to be realized, the nurse must change her status: either she must become an independent provider of care under separate contract to the patient and in a professional relationship to the physician as a cooperative principal; or the nurse must be employed by principals quite separate from those whose behavior she is to monitor. The third view, by contrast, does not require such a radical restructuring.

The view of the nurse as occasionally violating her duties as an employee in service of the higher interests of the public is strongly suggested in the ANA Code's admonishment to safeguard "the public" from the incompetent, unethical or illegal practices of any person. And such a view affords both comfort and alarm to the individual consumer. The comfort comes from the assurance that as a patient and while of diminished ability to defend himself from illegal incompetent practice, one is guarded by a variety of individuals who have a commitment to one's protection. But the alarm which the view raises is that on it the patient has no control, as he does with respect to his physician, over the understanding of and participation in the privileged informed of his case by individuals whose ethical commitments may differ from his own. Were the sole professional recourse of the nurse whose ethical scruples differ from those of the patient to refuse to participate in the case, that would be acceptable. And if the patient had the primary relationship with each nurse that he should have with the physician (so that he could have the same degree of confidence in the nurse's understanding and acceptance of his ethical quirks and commitments as a precondition of the relationship), then he could comfortably accept the nurse's watchdog function. But when the nurse's differences in ethical persuasion become her warrant to expose facts about the patient's life which he should want kept confidential, the nurse exceeds any warrant which the patient should want to support. The proper places for pursuit of the prohibition of practices which one finds intolerable are legislatures, institutional policy committees and state nursing organizations. If these forums are not responsible or responsive, that is a political problem requiring a political solution. But neither the unauthorized disclosure of confidential information to a public forum, nor the direct undermining of a patient's confidence in the physician should ever readily occur to the nurse as an appropriate means for dealing with what the nurse considers to be unethical behavior, if for only the simple fact that there is no culture-wide unanimity about what constitutes ethical and unethical behavior. Only when a criminal act can be prevented by such measures, and only such measures, as either patient or public disclosure of confidential information, should such steps be contemplated and then the nurse acts in the role of the responsible citizen rather than out of any special nursing duty. There are features of this third interpretation of the nurse's new role which ought to be preserved, those which point the way to a fourth. One of these features is its recognition of the diminished autonomy of the patient and the accompanying increase in vulnerability to both the paternalism and the impersonal technology to which medicine tends to fall prey, and to the occasional less-than-competent practices of physicians, surgeons, nurses and other personnel involved in delivering medical and health care.

"There are... limits that ought to be observed in the aggressive pursuit of the professional ends of the health care team members, limits which the patient is not in a particularly good position to enforce."

Another feature is that, however, diminished the patient's actual powers may be, all providers of medical and health care should be kept mindful of the fact that to practice on a patient is fundamentally a privilege which the patient extends and which the patient reserves reasonable control of in service of his own ends. There are, in short, important limits that ought to be observed in the aggressive pursuit of the professional ends of the health care team members, limits which the patient is not in a particularly good position to enforce. Finally, that remark provides the key to legitimizing the new role of the nurse, for it introduces into the discussion explicitly the concept of the team.

Elsewhere 14 I have discussed the Team model of physician/nurse relations. One of the relevant features of that model is that it requires a recognition of a different understanding of responsibility and liability than is embodied under the present view of physician as principal who controls the actions of nursing and allied support staff. Under the team model, the team providing services to the individual client functions with respect to accountability and responsibility as a team, represented by that individual most centrally involved in the particular phase of the patient's care being pursued at the moment, rather than always by the attending physician. The patient's ultimate responsibility is to his health care team. The comfort comes from the assurance that as a patient and while of diminished ability to defend himself from illegal incompetent practice, one is guarded by a variety of individuals who have a commitment to one's protection. But the alarm which the view raises is that on it the patient has no control, as he does with respect to his physician, over the understanding of and participation in the privileged informed of his case by individuals whose ethical commitments may differ from his own. Were the sole professional recourse of the nurse whose ethical scruples differ from those of the patient to refuse to participate in the case, that would be acceptable. And if the patient had the primary relationship with each nurse that he should have with the physician (so that he could have the same degree of confidence in the nurse's understanding and acceptance of his ethical quirks and commitments as a precondition of the relationship), then he could comfortably accept the nurse's watchdog function. But when the nurse's differences in ethical persuasion become her warrant to expose facts about the patient's life which he should want kept confidential, the nurse exceeds any warrant which the patient should want to support. The proper places for pursuit of the prohibition of practices which one finds intolerable are legislatures, institutional policy committees and state nursing organizations. If these forums are not responsible or responsive, that is a political problem requiring a political solution. But neither the unauthorized disclosure of confidential information to a public forum, nor the direct undermining of a patient's confidence in the physician should ever readily occur to the nurse as an appropriate means for dealing with what the nurse considers to be unethical behavior, if for only the simple fact that there is no culture-wide unanimity about what constitutes ethical and unethical behavior. Only when a criminal act can be prevented by such measures, and only such measures, as either patient or public disclosure of confidential information, should such steps be contemplated and then the nurse acts in the role of the responsible citizen rather than out of any special nursing duty. There are features of this third interpretation of the nurse's new role which ought to be preserved, those which point the way to a fourth. One of these features is its recognition of the diminished autonomy of the patient and the accompanying increase in vulnerability to both the paternalism and the impersonal technology to which medicine tends to fall prey, and to the occasional less-than-competent practices of physicians, surgeons, nurses and other personnel involved in delivering medical and health care.

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tured on the ethics and dynamics of employer/employee relations. The current ANA Code, specifically the sections we have been examining, may thus be read as a first attempt at delineating the responsibilities that any member of the health care team should have. Each member, not just the nurse, should be concerned to protect the patient against the unethical, criminal or incompetent practices of any person, where “unethical practices” are understood by reference to the constellation of values and beliefs of the patient and the agreements reached between the team members and the patient.

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Enormous obstacles to implementing such a team approach exist.19 Still, if we do perceive that nursing will not willingly return to the passive agent’s role of the past, and that the directives of the current ANA Code are for the most part laudable and form a prototype for the team’s ethics, then creating new professional structures, embedding them in practice statutes, altering third-party reimbursement and malpractice carrier’s regulations to accommodate necessary changes in compensation and liability protection, and altering educational curricula to provide multidisciplinary training in team dynamics and organization will be given a direction and rationale. But it is time to recognize and remedy the crisis in professional relations which has prompted nurses to take the lead in declaring independence, at least in theory, of the traditional view. The alternatives of transforming nursing into an independent profession of principals, making the nurse into an advocate with an explicit adversarial function, or encouraging nurses to engage in selective leaking of confidential information are ultimately less satisfying than would be developing new perceptions and organizational structures in which physician, nurse, social worker, occupational therapist and the like can work cooperatively as members of a team in the service of its client.

The nurse’s similarity to Hamlet lies, in part, in her lack of institutionalized support. As professionals, physicians, nurses and others recognize the value in principle of dealing with instances of incompetence and malpractice preventively. But the traditional principal/agent structure discourages perceptions of acts of questioning orders, practices and policies as anything but illegitimate and disloyal acts, and it is unlikely that those perceptions will change so long as the old relationships remain.

Footnotes
2 For a useful discussion of the legal rationale of having physicians bear these risks, see J. R. Waltz and F. E. Inbau, Medical Jurisprudence. New York: Macmillan Pub. Co., 1971 (Chapter 7: "The Liability of the Physician for the acts of others.").
5 C. F. Davis and Aroskar, op cit., p. 12.
12 Blumberg, op cit.