The ethical dilemmas of being an O.R. nurse

By Michael M. Burgess, Ph.D.

As a philosopher working in the ethics of health care, I see the problems of ethics and nursing, of health care institutions and nurses and the particular problems of the nursing profession itself, from a different perspective than nurses, or physicians, or even union leaders.

In the ethical review of nursing research, I have noticed that the type of research proposed by nurses, and the attitudes of some members of the research committees, make it difficult for this research to receive approval. Specifically, nurses tend to be interested in issues of patient satisfaction, self-management and education. Physician and scientific reviewers' skepticism of the value of these goals, and the validity of the research methods employed, often interfere with ethical approvals.

In ethical case consultation, problems may arise due to a lack of communication. Though often not intended, this lack of communication shows a lack of respect for the people (nurses) who must live with the decisions and treatments. For example, in one case, the nurses involved did not understand the need to support a family's choice of apparently meaningless surgery because the family treated the physician as the only decision-maker, and the physician did not explain the situation to the nurses.

It is obvious that nurses focus on different aspects of ethical issues. They will often suggest a procedure without commiting themselves ethically. In one case example, a patient accepted heroic measures. The nurses, however, saw the emotional pressure exerted by the physician and the family, and personally agreed with the patient's earlier rejection of the measures. The nurses realized that there was no easy answer, but questioned the validity of the consent. But there is nothing wrong in accepting treatment for the sake of one's family. The nurses had sought an ethical justification to challenge a decision with which they were uncomfortable.

The personal research of this writer lies in how present institutional and societal arrangements create, obscure, or resolve ethical problems. The ultimate goal of ethical research is to suggest viable alternatives. But this proves a more difficult task than might first appear. For example, on close scrutiny, consent to surgery is rarely valid informed consent. More detailed forms would not help and would formalize the procedure in a non-constructive manner. The problem is the relationship between the (nurse) informer and the person consenting, when the patient is not seen as responsible for the choice. The institutional setting requires that we pretend that they (patients) are (responsible), rather than really giving them the responsibility.

Role implications

The heavy professionalism and institutionalization of health care means that one is usually arguing for educated patient and public participation in individual health care decisions and health policy. Ethical analyses of the kind and power wielded by physicians in medical encounters have implications for the responsibilities and role of nurses.

Nurses are caught in a web of relationships which limit the exercise of their professional competence and ethics. The broad professional autonomy of the medical profession limits much nursing practice. This is compounded by the hierarchical organization of the hospital, where administrators are concerned with limiting fiscal freedom and legal liability.

Spending more time with patients than either physicians or administrators, the nurse must provide care consistent with such institutional authorities,

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observing the resulting inadequacies in patient care, often bearing the brunt of patient frustration and hostility, and risking formal or informal sanctions if one challenges the directives. The little region of professional discretion some nurses attain is usually creatively constructed by playing these two institutional authorities against each other. This is hardly the exercise of professional autonomy, which is premised on the recognition of competence and the need for freedom to apply professional judgement.

Professionalization of nursing

Professional autonomy is a popular phrase, and one mark of a profession. Theoretically, professional autonomy is based on ability and competence, and is a claim that professionals ought to have the freedom to exercise their professional judgement on consenting clients. Nurses' professional autonomy is limited by conflict with the medical profession's autonomy, concerns of hospital administration, and social conventions and attitudes. Hesitating to educate a patient who has unrealistic expectations and is about to be discharged following knee surgery, or calling the physician on call to authorize medicines are both cases of limitations of nurses' professional autonomy. In both cases, the judgement has been made by the nurses, but they must seek authorization before exercising their professional abilities.

Reimbursement for professional services is theoretically based on the extent of training for a position, the level of responsibility, and the number of hours worked relative to other professionals in a similar job market. Perhaps physicians, social workers and teachers are good comparison groups, although physicians typically train about twice as long. Nurses' reimbursement is limited by efforts to control costs of health care, limitation of responsibility by health care institutions and the medical profession, and sexism. For example, as health care economist Robert Evans has indicated, physicians still maintain income levels by increased intensity of servicing under fee-for-service billing. Social work, another well-known female dominated profession, is faced with decreased pay and increased accountability and case loads.

Legitimacy, or a culture's acceptance of professional roles, is theoretically based on client's voluntary relationship, or public and political groups consulting with a professional group. Nurses' legitimacy is limited by culturally and politically entrenched groups (i.e., physicians, hospital administration, seniority), attitudes supporting the status quo (conservatism of finances and health care, cure orientation), and internal conflict (what degree do nurses need to perform the tasks currently part of their job, and what should their jobs become?). For example, there is no good reason not to address the persistent inequities in access to health care in rural populations, and the high cost of providing very basic services through the emergency room, through nurse practitioner programs, as has been done in the United States.

The resolution of these problems of professional recognition must involve political action, likely through unions. As a family practitioner remarked in a class on ethics for medical students, the more that you feel unjustly or unethically treated by the health care system, the less compuction you will have in treating those with less power than you in the same manner. That does not justify it, but patients will suffer from the current mistreatment of nurses within the health care system. Nurses should fight for these changes for their own sake, not patients'. To argue for professional advancement so that patients might benefit is suspicious, and likely to stimulate distrust. People who are happy with their employment situations do better work, and nurses' work has to do with patients. That is probably as strong as the connection should be. If nurses want professional advancement, they should do it for themselves!

Moral responsibilities

Nurses' professional competencies and relationships define their moral responsibilities. In addition to the normal moral responsibilities which we all have as persons, nurses add professional moral duties. It should be mentioned that this relation-based notion of ethics is different from many more traditional theories, and is strongly based on work in the areas of practical ethics and feminism. But I find the use of rights (implied through duties and reponsibilities) pretty confusing and often meaningless; so I prefer this (relationship) approach for its concreteness and humaneness.

Nurses have moral responsibilities to each other. These responsibilities are often labelled col-

leagueality, mutual respect, honesty, and loyality. Nurses should be supportive of each other emotionally, communicate concerns directly and recognize each other's commitments. When you have a problem, talk to all involved who may be affected by your action. Correct each other "by going to the source," rather than reporting to those in authority.

Nurses have moral responsibilities to patients and the public. This is obvious. There is, however, a danger in the new emphasis on advocacy. Every health care professional, and lawyers as well, believe themselves to be the patient's advocate. Rather than being better represented, patients' own voices may often be lost in a sea of advocates. I am not suggesting that it is inappropriate to support and represent patients. But do not emulate the now discredited paternal model of the medical profession by deciding what is in the patient's best interests independent of patient participation.

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Remember the example of the nurses' complaint that patient's consent was not valid because it was influenced by the family and the physician. My analysis was that the nurses disagreed with the quality of life judgement made by the patient's family and physician, and accepted by the patient. This was not patient advocacy of a beneficial sort, but an attempt to substitute nurses' judgement for the patient and family's.

Nurses have moral responsibilities to other health care practitioners and their institutions. They have agreed to work within lines of authority and within particular relationships. This limits their choices and freedom to act. However, where these constrain or encourage apathy or mistreatment, nurses also have responsibiliy to challenge them. For example, when a nurse disagrees with a decision or policy, it should be discussed with the responsible parties. It should not be ignored!

Ethical conflicts

Nurses' professional or personal interests sometimes conflict with their moral responsibilities to patients or other health care professionals. A good example of this was the Alberta nurses' strike in 1988, in which each member was faced with a decision where loyalty and support to colleagues and self-respect conflicted with patient care. It was also complicated because striking seemed to promote patient care in the long term by neglecting it in the short term. But the moral basis for the strike was the right to reasonable work conditions within which to care for patients, including some of those who were neglected in the act of striking.

Self-serving image

A careful analysis should try to determine which action best promoted the moral duties involved. But ethical analysis by nurses which supports the strike will always appear biased and self-serving, even if it is a good analysis. To argue for the strike on the basis of patient interests promotes this self-serving image.

An example of personal interests conflicting with patient interests is surgery and the risk of HIV infection, where confidentiality and patients' equal treatment may be compromised to protect practitioners. Good information on the risk of infection and reasonable universal precautions reduces the moral weight of the personal interest in protection.

Nurses may face ethical issues where responsibilities to patients conflict with responsibilities with colleagues. A well-known case is the Tuma case from the United States. Nurse Jolene Tuma was sanctioned for unprofessional conduct for discussing alternative forms of care with a cancer patient and the family, at the patient's request *(Supreme Court of the State of Idaho, No. 12587, Twin Falls, Idaho, October, 1978; filed April 17, 1979)*. The professional association agreed with the physician that nurse's obligation to the physician not to disclose such information was stronger than the responsibility to answer patients' questions. The suit was overturned in court due to lack of specific requirements in the professional code.

Supportive education

More frequently, the conflict is between patient requests about diagnosis or prognosis and physicians' or families' attempts to keep patients ignorant. The responsibilty of collegiality is not one of blind support, but of supportive education. If a colleague's actions or decisions are not in a patients' interests, discuss it with the colleague. Do not merely withdraw, or ignore your colleague's work.

It is also possible for an ethical issue to arise from conflicts between various responsibilities to

patients. Whenever a patient exercises the right to refuse treatment in a case where you believe they should accept it, or accept in cases where you believe they should refuse, the ethical conflict is between your responsibility to respect patient autonomy and the responsibility to act in the patient's best interet. Typically, the most that you can do is talk to the patient, or to ask the physician to do so.

The dilemma of understaffing

The conflict may also be between responsibilities to different patients, such as in situations of understaffing. The dilemma of how to allocate scarce time is a difficult issue whose best resolution typically requires changes in policy, funding or staffing procedures. Often the best that one can do with the immediate problem is discuss the situation with your colleagues, and explain the situation to patients who may be confused by the change in levels of attention and priority.

Yet another source of ethical issues are conflicts of responsibilities to individual patients with responsibilities to the public, as in cases of contageous or infectious disease, job-related risks, and in lifestyle related illness. When third parties are placed at risk of injury or disease by the action or simply the condition of patients, it is difficult to maintain confidentiality.

Perhaps one of the most important and practical questions to ask of each of these cases is whether disclosure to any source is the least offensive means of protecting those at risk. Furthermore, in many cases disclosure simply will not have an effect, so cannot be justified. Self-righteousness often tempts us to disclose without careful ethical reflection, and these cases try our self-control.

There is a growing interest in surgical research, and as in many forms of medical research, nurses are often faced with the task of informed consent. It is important to realize that patient interests may conflict with research interests. "Research interests" are a complex of investigator, institution, perhaps company and future patients, or the publics' interests in pursuing the research. On the model of clinical trials, all experimental procedures, and additional monitoring, must be well distinguished due to patients' tendencies to assume therapeutic value.

Bioethics - possibilities and impotencies

There are ways that bioethics can assist nurses, although the cliche "No answers" is only a slight exaggeration. Nonetheless, those of us working in bioethics form a supportive community and share some useful methods. The methods of ethical analysis for cases are helpful to learn, but practitioners must watch out for overzealous advocacy. The ability to ethically analyze practical moral issues should lend clarity and humility, not authority. Bioethics may also assist nursing to gain in legitimacy. Working with other professionals, including other ethicists, will help give nursing expertise its proper place in ethical analysis and patient care.

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"Grassroots" efforts are the most likely to work, and the least authoritarian. It is therefore most appropriate for members of the nursing profession to seek education and form groups with each other and other colleagues in health care. Within hospitals, nursing may gain in recognized legitimacy through their role on ethics consultations, and on ethics committees. On the national scene, the Canadian Bioethics Society requires nursing representation on its executive and encourages participation of nurses in the Society's activities.

Conclusion

In conclusion, I have three comments. First, be bold about professional interests. Just as all persons are due respect of their autonomy, so nurses are owed professional autonomy to exercise their professional competencies.

My second comment is negative. Nurses must be careful about advocacy and avoid the excesses of what could be characterized as paternal physician models. Finally, professional and personal integrity require that nurses baldly refuse to trade relationships for technique. ■

About the author

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