AMERICAN NURSE: QUO VADIS?

by

BECKY COX WHITE

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Approved by:

Manuel M Davenport

Manuel M. Davenport

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ABSTRACT

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Becky Cox White, R. N.

Faculty Advisor: Dr. Manuel M. Davenport

Autonomy is generally diminished within society. The effects of this diminution are examined in two groups: hospitalized patients and hospital nurses. Hospitalized patients experience reduced or absent autonomy as a result of 1) impaired physiological functioning; 2) impaired psychological functioning; 3) insufficient medical information upon which to make informed choices; and 4) expectations imposed upon them by health care personnel who view patients according to Parsons' sick role. When health care professionals provide patients with salient medical data, these impairments are ameliorated and improved health care outcomes are obtained.

Hospital nurses suffer diminished autonomy due to 1) lack of a precise definition of nursing and its scope of practice; 2) unstandardized educational processes; and 3) employee status which demands subjugation of nurses to hospital administrators and physicians. When nurses practice with greater independence as in, for example, a primary care structure, higher levels of patient care and nurse and physician job satisfaction are achieved. That recognition of nursing autonomy will assure patient autonomy is demonstrated.

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DEDICATION

This paper is dedicated to Joyce Schmidt, R. N., and Carole Eshenbaugh, R. N., whose personal and professional autonomy have been an unfailing source of inspiration.

TABLE OF CONTENTS

THE NATURE OF AUTONOMY. 1

Autonomy and Society: Heidegger's Perspective. 8

Autonomy and Society: Jaspers' Perspective 10

ILLNESS: A FURTHER CONSTRAINT ON AUTONOMY 13

From Agent to Patient: A Rite of Passage 13

Constraints on Agency: The Patient 17

CONSTRAINTS ON AGENCY: AN EXTENSION OF SOCIAL VALUES. 20

Constraints On Agency: The Health Care System. 21

Increased Autonomy: A Mandate for Changing the System. . . 23

NURSING: THE QUASI- PROFESSION 36

Nursing: A Brief History 36

The Current State of the Art and Science of Nursing. . . . 48

DEFINING NURSING: THE BASIS FOR AN AUTONOMOUS PROFESSION. . . 52

Health: The Basis for a Definition of Nursing. 52

The Definition: A Basis for Change 54

AUTONOMY IN HEALTH CARE: FURTHER JUSTIFICATION. 60

A History of the Development of the Professional Ethics of Nursing 60

The Professional Ethics of Nursing: Where We Have Been . . 63

The Professional Ethics of Nursing: Where We Are Now . . . 66

The Professional Ethics of Nursing: Quo Vadis?. 75

Autonomy: The Foundation of Patient Rights. 79

Nursing Autonomy: A Necessary Condition for Patient Autonomy. 80

CONCLUSION 81

ENDNOTES 82

SUPPLEMENTAL SOURCES CONSULTED 91

VITA 93

The fundamental issue of this paper is autonomy. The claim will be made, generically, that autonomy is desirable for every human being as a necessary component of self-actualization. Specifically, I will claim that autonomy is a necessary pre-requisite for the delivery of humane medical care to the sick and injured. More specifically, I will seek to establish that such autonomy must reside within patients themselves, that the current health care delivery system denies patients autonomy, that the Registered Nurse is uniquely potentially capable of maximizing patient autonomy, and that the Registered Nurse will succeed in assuring patient autonomy if and only if unhampered in the definition and removal of obstructionsto patient autonomy, which requires that nursing become an autonomous, independent, profession.

THE NATURE OF AUTONOMY

Why is autonomy important? The answer lies in the recognition of a fundamental feature of human nature.

Human beings are unique among sensate biological species by virtue of their ability to reason. While one can by no means assert that human beings always act in a rational manner, their capacity for rational thought cannot be denied. To be human, in the fullest sense, is to possess the ability, through reason, for self-determination. Thus, Aristotle, writing in the fourth century B.C., notes: "That perceiving and practical thinking are not identical is therefore obvious; for the former is universal in the animal world, the latter is

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found only in a small division of it [i.e., among humans]."[1]

It is from this ability to reason, to examine data, to evaluate choices and consider varying results which would accrue from such choices that autonomy arises. And here a caveat is needed, for I am not suggesting an unlimited freedom, but a freedom constrained by reason. The concept of autonomy is grounded in two distinct, but (in this context) inseparable components--freedom and reason; and neither can stand alone. Reason, used in an evaluative manner, delimits choices; but such reason is sterile in the absence of freedom to choose. Freedom, untutored by reason, gives rise to anarchy.

Webster defines autonomy as having the right of self-government.[2] Immanuel Kant, the Eighteenth Century German philosopher, defines it as the individual's right to be his own law-giver on the basis of his own ability to reason.[3] For Coleman, autonomy is "adequate self-reliance, responsibility, and self-direction--together with sufficient independence of social influences."[4] Any abridgement of the freedom of self-legislation constitutes a denial of another's humanity. Such a denial relegates a person to a sub-human status; viz., the victim of such denial is dehumanized, is made an object, becomes a thing rather than a person. A person in whom reason and volition are absent is often seen as less than fully human. Thus, in summary, to be human is to possess an ability, through reason, for self-determination. To be autonomous is to freely exercise that ability.

Freedom and free choice have been valued in western civilization for centuries; yet these concepts and their import are not peculiar to

any nation or hemisphere. The ancient Greeks, in their legends, immortalized Icarus' winged pursuit of freedom. For Aristotle, the good life was attainable only through choosing and choosing well.[5] For Augustine and St. Thomas Aquinas, intellect and freedom of will were the means by which one attained self-actualization and union with God. English philosophers John Locke in the Seventeenth Century and J. S. Mill in the Eignteenth Century, articulated the necessity for autonomy in persons' realization of their own, self-designated goals. In the Twentieth Century Jean-Paul Sartre, the French philosopher, held persons are--that is, exist--only to the extent that they act volitionally.

But this emphasis on autonomy has not been exclusively within the purview of the philosopher. Respected thinkers of all spheres and eras have proclaimed its merits. Every American school-child can recite Patrick Henry's rousing proclamation: "Give me liberty, or give me death!" The Italian poet, Dante Alighere, declares, "He goes seeking liberty, which is so dear, as he knows who for it renounces life."[6] Dostoevsky proclaimed, "All man wants is an absolutely free choice, however dear that freedom may cost him and wherever it may lead him."[7] Thus we see that the capacity for and exercise of autonomy have long been among humankind's most revered and cherished tenets. It may even be said that the free use of reason constitutes the essence of humans.

But why is the issue of self-governance, of autonomy, so important in the realm of health care? By way of answering that question, we must first examine the import, for persons, of autonomy, and the effects

upon them when this autonomy does not obtain.

All living things are motivated by two fundamental principles--survival and "actualization of their potentialities."[8] In human beings, this actualization has psychological as well as physiological components. Among the psychological needs for self-actualization we find the familiar needs for love, security, acceptance, approval, and the like; but equally vital are such qualities as competence, self-esteem, self-identity, worth, value and meaning (of one's life), and hope. The import of such qualities may be stated as follows:

> "Each person needs to feel capable of dealing with his problems. Seeing oneself as incapable of coping with a stressful situation is conducive to confusion and disorganization....Closely related to feelings of adequacy and social approval is the need to feel good about oneself, to feel worthy of the respect of others. Usually personal worth is judged largely in terms of those in one's milieu. If an individual measures up to these standards--for example, in terms of physical appearance, achievement, or economic status--he can approve of himself and feel worthwhile.... Intermeshed with feelings of self-esteem and worth is the sense of self-identity. This, too, is heavily influenced by significant others and by the individual's status and role in the group."[9]

Thus we see that persons need to feel in control of their circumstances and capable of handling the events of their lives; and that their success in such efforts can be, to a great extent, influenced by their interactions with their environment. In summary, we see a strong correlation between one's self-esteem and sense of well-being with the degree of control one is able to exert over one's life events.

That such feelings of control have import for persons is reflected in the concepts of positive mental health, delineated by the Joint Commission on Mental Illness & Health, and summarized by Manfreda.

These indicators of mental well-being include an attitude toward individual self; growth, development, and self-actualization; integrative capacity; autonomous behavior; perception of reality; and mastery of one's environment.[10] To the extent that such indicators obtain, a person possesses mental health. These healthy self-concepts do not magically appear, full-blown; they begin to be developed (or not) from early childhood and are dynamic throughout a lifetime. This on-going process represents the on-going interaction between a person and her environment, with the person ever re-evaluating herself, her world, and her relationship to that world. When a person perceives herself as being controlled by her world rather than the contrary, she becomes depressed and further impaired in her ability to function successfully in her environment.

The importance of environment cannot be over-emphasized, for human beings do not exist in a vacuum. Rather, humans live in a world which impacts against them in countless ways to which they then react. The nature of human actions, then, has dual determinants--the stimulus and the response. To some degree, people are powerless to control the stimuli which impinge upon them, yet are generally considered to be capable of controlling their responses to such stimuli. Yet to assume such control of response may be unrealistic, for how people respond to a stimulus is dependent upon self-image, and self-image can be determined by one's environment. The crucial points here are that persons behave in ways that are synchronous with self-image; viz., the person whose self-image includes his autonomy will move to act upon his environment, whereas the person who sees himself as helpless

will be more passively acted upon by that environment; and that this self-image is, at least partially, determined by previous interactions and the extent to which these interactions realized or thwarted the individual's goals. Deci puts this concept more succinctly: "The organism operates within a physiological, psychological, and environmental context, which may exert varying degrees of influence on behavior. Within this context of environmental and person forces is an executive, termed the 'will,' that constitutes the human capacity for self-determination. The will may or may not be operative in relation to a particular behavior or behavioral sequence. To the extent that the will is operative, we say the person is being self-determining."[11]

In persons wherein the will is non-operative, a variety of reactions may be observed. Responses such as anger, hostility, frustration, anxiety and aggression are common and need not be perjorative. Such emotions may, in fact, stimulate the person to address the environment more assertively, to "take charge" of his life and to make circumstances conform more closely to desires. When, however, these individual efforts are repeatedly unsuccessful, more undesirable and unproductive responses begin to appear, e.g., rage, withdrawal, depression. Persons who consistently fail in their efforts to determine their environments will ultimately discontinue those efforts, becoming puppets which are buffeted about by circumstance. This assessment is supported by Deci when he notes:

> "As people continue to receive negative information, they gradually lose their motivation to respond, their rate of learning slows down and they become emotional and dependent.

> In short, they lose their willfulness; their sense of competence and self-determination becomes severely undermined, and they gradually give up making active choices.... In its extreme pathological form, severe depression results. When people believe that responding is useless, they become passive and there is no apparent agression.... Depressed people lose the belief in themselves as effective human beings; they lose their appetites for food and sex and their desires to work and to relate to others."[12]

Seligman concurs with this evaluation when he charges that this passivity is adaptive behavior; a "learned helplessness."[13] Such helplessness protects persons from further failure, hence further damage to self-esteem, by taking them out of the action. The person who relinquishes control, (or has it usurped) cannot be held responsible for outcomes. But this is surely a negative protective maneuver, resulting in on-going, increasing helplessness which erodes those previously delineated qualities of mental health--e.g., autonomous behavior, self-actualization, mastery of environment, etc. The helpless person becomes an object to be acted upon, comes to resemble and be treated as a thing, loses his personness--all of which denigrate self-image, thus further reducing the ability to be autonomous.

Loss of autonomy and depression are no strangers to modern man. It has been estimated that 20 million Americans will suffer some form of depression in any given year[14] and that only 25% of all severely depressed persons for whom treatment would be beneficial will receive assistance.[15] The pervasive nature of concern over loss of autonomy is readily attested to by the proliferation of encounter groups and work-shops in assertiveness training, whose goals are to increase the knowledge of self and success in controlling one's life.

The charge has been levelled that diminished or absent autonomy is inherent in our world today and, indeed, is a by-product of modern society. It is certainly true that this charge may be variously illustrated by the frequently frustrating relationships of people in society. The particular outcomes will vary depending upon which social system the citizen confronts, e.g., the legal system, the medical system, the governmental bureaucracy, etc., but the general outcome and resultant attitude is dishearteningly similar: You can't beat the system. You can't win. You can't fight City Hall. And in those rare instances where one "wins," that win is all too often a Pyrrhic victory. Much of this frustration and failure can be linked to the paucity of human interactions and the proliferation of human-machine interactions, the paradigmatic illustration being, of course, dealing with the computer. This helpful device seems to have been dropped, as deus ex machina, into society where it is seen as answerable only to other Gods or, perhaps, other machines. At least when computers run amuck, the standard explanation is, "The computer is down," implying autonomy on the part of the computer. Though programmed by human hands, once programmed, the computer acquires an independent existence for which human beings are unable or unwilling to assume responsibility. Success or failure is consigned to the computer, with victims of its actions bereft of redress regarding the outcomes.

Autonomy and Society: Heidegger's Perspective

How is it that society is afflicted by such a pervasive impotence? Various hypotheses have been proffered by various thinkers. The assessment by the Twentieth Century German Philosopher, Martin Heidegger, saliently addresses the questions this paper will examine, for Heidegger

examines the issue of the place human beings do, as well as should, occupy in a technologically advanced society. Heidegger charges that human beings have failed to understand the underlying essence, the "whatness," of the technology which is ubiquitous in society today. Today technology is seen as the end, rather than as a means to ends. But in actuality technology has two components; it is a means to an end, yet it is also a human activity. To currently understand and to master this technological age is to understand the proper interdigitation of persons and machines.[16] And this relationship, properly realized, is persons using tools which they themselves created to attain ends which they themselves have defined. For Heidegger, "Technology is a mode of revealing."[17] That is to say, we should use technology to help us learn more about our world, but this cannot occur if that world is defined in terms of machines. If we allow the parameters of our knowledge of the world to be defined in terms of machines, we the people are relegated to caretakers, reduced to the care and feeding of the machines which were introduced for the care and feeding of human beings. We sacrifice human freedom to technology's demands. The dehumanization of persons is not inherent in technology, but lies, if it must lie anywhere, in the failure to establish an appropriate, autonomous relationship with it. As Heidegger notes, "For man becomes truly free only insofar as he belongs to the realm of destining and so becomes one who listens and hears, and not one who is simply constrained to obey."[18]

Because one's concept of self is derived from one's concept of his world, the person who sees that world as a technologically complex machine must, by extension, see herself as an insignificant tool to be

used for the maintenance of the great machine. Thus, modern citizens see themselves and each other not as agents, but as objects acted upon; not as humans, but as things to be used; not as autonomous, but as manipulated. This failure of human beings to understand themselves as masters of their fates has, for Heidegger, the most heinous consequences; such persons deny the essence of their own humanity and treat others, not as ends in themselves, but as means merely, and they allow themselves to be so treated and used.[19]

Autonomy and Society: Jaspers' Perspective

Twentieth Century German Existentialist, Karl Jaspers, foregoes Heidegger's mechanistic analysis, but retains his relationship of the one to the many. Jaspers looks at this relationship of humans within a society from a different perspective: the individual within the mass. Like Heidegger, Jaspers claims an alienation exists between human beings and their world, but he posits a different (albeit closely related) etiology. Jaspers examines modern society from an historical viewpoint, noting changes which occurred in response to the industrial revolution. This social upheaval resulted in drastically increased capabilities for consumption on the part of the consumer. The newly attained capacity for mass production made it possible to provide an ever-expanding array of goods and services for ever-increasing numbers of people. With the emergence and rise of a large middle class, society came to reflect the wants and needs of the "average person." While this philosophy indeed generally served the more general needs of more people, it lost its ability to meet the specific needs of the unique

individual. The individual lost his identity and became,ideologically, an unidentifiable ort in an amorphous mass, the result being, according to Jaspers, "Man as a member of a mass is no longer his isolated self. The individual is merged in the mass, to become something other than he is when he stands alone. On the other hand in the mass the individual becomesan isolated atom whose individual craving to exist has been sacrificed..."[20] Thus we find the person sacrificing the freedom of individuality for the common societal "good." And what reward does one gain from having made this sacrifice?--one is rendered expendable. "When the average functional capacity has become the standard of achievement, the individual is regarded with indifference. No one is indispensable. He is not himself, having no more genuine individuality than one pin in a row, a mere object of general utility."[21]

Let us now summarize the ramifications of this choice. When society developed the capability to provide more people with more goods more of the time, it attained this capability only by sacrificing the individuality and uniqueness of each person. Given the choice of meeting the needs of the individual and meeting the needs of the masses, society chose to do the latter. The devastating extension of this choice is society's perception of human beings as nothing more than interchangeable parts in the greater machine that has become society.

Thus if we again reflect on the components of autonomy, reason and freedom, we find that it is just these components to which Heidegger and Jaspers, respectively, speak. Heidegger maintains that we have failed to exercise that reason which would permit our

rational understanding of and, thus, control over technology. Jaspers chastises us for subordinating freedom and choice to convenience whereby we sacrifice our individuality to an amorphous mass in which we then become lost, perhaps irretrievably.

ILLNESS: A FURTHER CONSTRAINT ON AUTONOMY

Having examined some of the constraints extant in society which generally impair autonomy, we are now able to proceed to an examination of the inhibitions to autonomy in the individual who, because of illness or injury, has been hospitalized.

To begin with, illness is frightening, and being hospitalized can be terrifying. Most people have a knowledge of at least one person who was hospitalized and died or came out with a diagnosis of chronic or terminal illness. Thus, no matter how logical the decision for hospitalization appears, the fear of suffering a similar fate is present in the mind of the person who has acquired the status of "patient." Coupled to this fear is the dehumanizing process through which people are transformed into patients.

From Agent to Patient: A Rite of Passage

The initial encounter between the health care system and the person (i.e., the potential patient) usually occurs at the behest of that potential patient. (Obviously, this is not the case with the person who, following a cataclysmic medical crisis, has been rendered completely helpless and incapable of making a choice. That this person does not enter the system volitionally may serve to exaggerate the process which will be henceforth discussed as he was, by virtue of circumstance, denied the initial decision to become a patient). People elect to become patients for multiple reasons, perhaps most cogently discussed by Jonathan Miller, in his brilliant BBC presentation, "The Body In Question." According to Miller, there are four different, but interrelated, perceptions which can result in a person

defining himself as being sick and in need of medical attention. These perceptions occur in response to some discernible bodily manifestation which the person interprets as abnormal. Such signs, then, may be perceived in one or more of the following modes.

1. The sign may be one of "intrinsic nastiness;" viz., it is, in and of itself, immediately and overtly undesirable. Pain is generally so considered.
2. The sign may infer a threat to life and/or bodily integrity. While not immediately noxious in a physiological sense, it is a harbinger of evil. Breast lumps in women meet this criterion.
3. The sign may reduce efficient functioning, precluding the fulfillment of a normal life style. The tremor of Parkinson's disease, for example, can limit success in both occupational and recreational activities.
4. The sign may be a source of embarrassment because it is readily observable to others, e.g., facial lesions.[22]

A single sign may elicit one or several of these interpretations. One of Miller's illustrations is angina pectoris (the pain associated with the inadequate supply of oxygen to the heart). The chest pain alone motivates one to seek medical assistance for relief, but also, because of its association with the vital organ affected, provokes fear for future life and health. Angina sufferers are severely incapacitated by this pain, avoiding any activity (except, perhaps, efforts to get to their relief-producing medication or to a phone to summon assistance). Embarrassment may be present, especially

in the victim who prides himself on being "in good condition." There is a readily observable commonality among these four perceptions: they objectively and/or subjectively alter a person's self-image such that she considers herself to be sick, and to be sufficiently sick that she requires professional assistance to restore an optimal or normal functional state. In other words, a person views herself as being, in some way, unhealthy and impaired. Ergo, the person places herself in the role of patient. This choice by persons is not the issue here; what is important is how the medical community--particularly the hospital community--responds to that choice.

The person who is hospitalized falls victim to not only his illness but also to institutionalization. He becomes, quite literally, incarcerated in a facility wherein he is stripped of clothing, modesty, privacy, and the emotional support of family numbers or significant others except during institutionally designated hours. By way of replacement the patient is issued a scanty, ill-fitting uniform, a perfunctory and usually inadequate dilimitation of the rules by which he is expected to abide, multiple observers/recorders who monitor his most private functions, and a chronicle of said functions to which large numbers of persons (excluding only the patient himself) have access. He is consigned to a room which a vast array of strangers intermittently enter, without knocking, to talk about him among themselves, but to rarely talk to him. Thus insidiously but inevitably the patient is stripped of dignity and capacity for self-government. Adrift in a sea of jargon and of nameless, faceless white coats, the patient becomes increasingly confused, frightened, angry, and

depressed, feelings which are compounded by a perception of himself as being powerless to alter the situation. Duff and Hollingshead, in data gleaned from extensive interviews with hospitalized patients, found these interpretations and reactions to be widespread, and note: "The despair of patients was revealed by their frequent references to the hospital as a jail and themselves as its prisoners. For the panic-stricken patient there was no way out of the dilemma that enmeshed him--he was a prisoner of his illness and under the complete control of others."[23] Thus it is not surprising that patients come to see themselves and their hospitalization negatively. The process by which this jaundiced view comes into existence is highly complex and involves actions and reactions, on the part of the patient and her caregivers, which may largely derive from unconscious or subconscious motivations and from arbitrary and subjective value judgments. Because the medical system is a social microcosm, the system's participants have roles circumscribed by rights, duties, and expectations. Let us first examine the "role" which is played by the person turned patient.

Miller observes that the person who enters the medical system does so via a "rite of passage,"[24] and that the change of status from healthy to sick is actually a change in social status whereby one surrenders the role of agent to one of patient. When a person, through the symptomatic calculus, defines himself as sick, he volitionally adopts the role of patient and thereby transforms himself from a self-sufficient human being into someone who needs the help of others.

This concept was first delimited by Parsons in his discussion of what he terms "the sick role."[25] This role is, in fact, well defined, especially in those instances where hospitalization occurs. The hospitalized patient is subject to four expectations which derive from the sick role. She is, by virtue of illness, exempted from the responsibilities of her normal (i.e., non-sick) social roles. Because the sick person cannot, unaided, resolve her crisis, nor will the illness away, she must be "taken care of."[26] The person is expected to view illness as undesireable and obligate herself to "get well." The patient's fulfillment of this obligation entails seeking technically competent help (usually a physician) and cooperating with this chosen professional.[27]

A summary of the circumstances to this point shows us a person who, because of a self-recognized functional abnormality which she is incapable of managing, seeks professional advice and enters a structured system which has its own expectations and definitions of that or any other person. (It is of interest and import that the patient may be unaware of or in disagreement with the system's expectations of her. This problematic happenstance will be more fully examined later).

Constraints on Agency: The Patient

In addition there exist constraints which are imposed upon the patient by the nature of illness alone, for illness is a restrictive phenomenon. Illness impairs physiological functioning, e.g., through pain, weakness, etc.; it impairs psychological functioning, e.g., through fear, thwarted goals, altered self-image, etc. Further,

treatment of illness may impinge upon intellectual functioning, e.g., in the patient obtunded by drugs. And, to the extent that a person gives himself up to a technically competent medical professional, he is required to abrogate his status as an autonomously functioning human being. Much of this requisite abrogation of autonomy results from physicians' reluctance to share pertinent information with patients, and the power of physicians, derived from their exalted position within the health care hierarchy, to forbid other health care personnel to provide the patient with the information necessary for making rational choices. Thus the limitations imposed on patients by illness and the physician-dominated medical system serve to hamper both freedom and reason and, thereby, autonomy. To summarize what all this means to the patient, I turn to Edmund D. Pellegrino:

> "Thus, being ill is in many ways a state of diminished humanity. The patient loses most of the freedoms which we regard as specifically human. His body is no longer the instrument of his will, and he cannot pursue the ends he has defined for his life. The patient is further impeded by pain, disability, or malaise. He has neither the knowledge nor the skill to repair the defect. He becomes dependent upon the power and good will of another person--the physician. The patient lacks the conditions for a free choice of what course he will take in coping with his difficulty. His concept of what is desirable and healthy is limited by the value the physician holds of what is good for him. Finally, the illness shatters the patient's image of himself and his existence, and challenges his identity and his values.
>
> In short, illness takes from us those things we cherish as most human--our freedom to act in pursuit of aims we ourselves define; to make rational, free, and informed choices; and to do so from a position we have defined as our own. When the patient seeks out the physician, he is implicitly asking, at least, to be restored to a more fully functional state. That state conforms to his vision of what is required to enjoy a human existence, one in which the freedoms lost in illness are once again operative.[28]

As if this portrait of a patient were not sufficient cause for despair, there is one final concern to be addressed--the vulnerability of the patient. In a foreign milieu, largely isolated from traditional support mechanisms, incapacitated physically, psychologically, intellectually, and operationally, the patient is at the mercy of the health care professional. And the health care professional can never be too keenly aware of the patient's disadvantage and, indeed, should keep it foremost in her mind. The danger to the patient of any failure on the part of the health care professional to recognize her all-encompassing incapacitations is addressed by Parsons: "... the combination of helplessness, lack of technical competence, and emotional disturbance make [the sick person] a particularly vulnerable object for exploitation."[29] It is such a potential for exploitation that must weigh heavily upon health care professionals, admonishing them to seek out and honor those beliefs and desires which are unique to individual patients, rather than (as is now all too frequently the case) imposing their own beliefs and values upon those individuals whom they purport to serve.

CONSTRAINTS ON AGENCY: AN EXTENSION OF SOCIAL VALUES

If we refer back to Heidegger and Jaspers, we may comprehend why such exploitation is currently extant. Medicine sees itself as a tool by which the health of society (as opposed to the individual) is attained and maintained. Patients see themselves as tools having their own utility within the societal effort, as tools now in need of repair. The "patient-tool" presents itself to the "medical-tool" to be fixed. Thus both tools work to maintain societal homeostasis. We must now examine whether or not this concept is inevitable and, if not, how it may be altered and what advantages would accrue from its alteration. On the basis of pragmatic concerns I will address these issues only from within the framework of the hospital setting.

First and foremost, we must acknowledge that any concept humans have of themselves as objects rather than agents is internally derived; viz., the person so assesses himself. Society may, of course, reinforce that self-image, but cannot mandate its adoption or perpetuation. The person as patient who sees himself as a tool to be cured (i.e., fixed), the physician who views himself as a tool which diagnoses and cures (i.e., repairs), or the nurse who defines himself as the tool by which patient and physician effect these desired outcomes will act in dehumanized and dehumanizing ways commensurate with those self-images. On the other hand, the patient who defines his own life goals and seeks assistance from (as opposed to domination by) health care professionals when illness obstructs his ability to realize those goals is a free agent. Likewise, the physician and

nurse who define themselves as knowledgeable professionals who choose to guide (rather than unilaterally structure) the patient's goal-oriented endeavors will interact with the patient and each other (rather than issue arbitrary directives) to achieve those goals. This will entail some significant changes in attitude and self-image on the part of all participants, all of whom must come to regard the patient as the ultimate arbiter in the therapeutic endeavor, for it is the patient who is most profoundly affected. I do not assert that this will be easy, only that it is possible. For, to a large extent, one's world is what one makes it, viz., how one defines it. And while human beings frequently cannot control what happens to them, e.g., becoming ill or injured, they can control their responses to life's events. It is in changing these responses that the potential for autonomy lies.

Constraints On Agency: The Health Care System

How, then, do patients and health care professionals go about changing their responses within the hospital setting? Logically, the first step is the recognition that change is necessary and/or desirable, that the present system does not operate with optimum efficiency. This recognition is currently extant, largely as a result of the monotonic rise in law suits against health practitioners and health institutions. The next step is to determine in what ways the system is lacking. This step, too, has received analysis, resulting in articulation of the primary deficit: the system is failing to meet the needs and goals of its clinets. This failure is attested to, not only by the law suits, but also by the reluctance of large

numbers of people to utilize the system or to postpone its utilization until their health situations deteriorate.[30] Another indicator of this failure is the widespread non-compliance of patients with prescribed thereapeutic regimens, viz., patients don't follow health care recommendations. (For example, a study at the University of Maryland found that only 40-45% of persons afflicted with high blood pressure comply with the therapy recommended for them).[31]

One must ask why the needs of patients go unmet. The answer is really quite simple: the patient's needs and expectations of the system are only rarely, if ever, solicited. Rather, medicine addresses itself to symptoms, diagnoses and treatments; it addresses its efforts toward peptic ulcers and hypertension, diabetes mellitus, etc. Medicine rarely address Mary Smith--wife, mother, daughter, professor, researcher, Girl Scout leader, tennis buff--who happens, coincidentally, to have been diagnosed as having a peptic ulcer, hypertension, diabetes, whatever. The person who is Mary Smith becomes, in medicine's eyes, the peptic ulcer in room 306. Having been so delegated, Mary is then treated as the "textbook" picture or the "average" peptic ulcer. To paraphrase, medicine meets its own needs to diagnose and treat, but has made no effort to treat Mary Smith, the person behind the diagnosis. This problem is succinctly expressed in van den Berg's exhortation to physicians to "act in the interest of the patient and not in the interest of his illness. Modern medical science observes no difference...."[32]

But, of course, there is a very real difference between a person and her illness. Persons have illnesses; the converse, contrary

to popular medical management, is not true. If medicine wishes to help the person, it is the person's needs which must be met. Thus, the heart of the solution to the issue of patient care lies in increased and improved communication between the patient and the health care professional. More specifically, the patient must be an active participant in her own health care process. She must express, not only her signs and symptoms, but her needs, wishes, and expectations. The health care professional must acknowedge such patient expressions and incorporate them into an individualized therapeutic format, one which is developed to meet the particular requirements of a particular person-patient. This therapeutic plan must then be discussed with the patient to ascertain whether the patient can successfully incorporate it into her lifestyle; if not, the plan must be tailored to assure that the mutually agreed upon therapeutic goals can be achieved. Such an approach requires considerably more communication than now generally occurs. Not only must the patient's input be encouraged, but the patient must be informed of the purpose and nature of any diagnostic studies, of the diagnosis, when established, and of various treatment alternatives. This information must be presented in a language the patient can understand and in a manner which allows the patient to clarify and respond to the information. If such an approach were adopted, what would be the outcome?

Increased Autonomy: A Mandate for Changing The System

Because the current health care system allows minimal patient participation or autonomy, its change is warranted. However, for

that same reason, any postulations regarding the results of change are necessarily of a speculative nature. Nonetheless, if the constraints on patient autonomy are studied in light of recent research in the field of patient's responses to hospitalization and recommended therapeutic regimens, some interesting and encouraging predictions are seen.

We recall that four factors obtain which inhibit autonomy in patients: impaired physiological functioning; impaired psychological functioning, due largely to anxiety and fear; lack of sufficient medical information upon which reasoned choices can be made; and expectations imposed upon the patient by the health care system. Let us now examine each of these constraints in greater detail, and expose some of the fallacious and mythical thinking which surrounds them

It is true that many patients suffer physiological malfunctions to some degree. It may be, in fact, such malfunctioning which initially leads a person to seek medical assistance. Because the person lacks the requisite knowledge to manage this disability, she is dependent upon her medical caregivers. But this dependence need not--indeed, must not--be complete. If the patient, who is normally independent, is allowed or encouraged to become totally dependent upon health care professionals, she runs the risk of acquiring the learned helplessness, earlier described, with its attendent depression. It is, for reasons not fully understood, easy for health care professionals to forget that patients come for care on the basis of their own autonomous decisions, and that prior to hospitalization (and, hopefully, after it) patients are independent agents who daily make numerous decisions

in their life management. This capability must be preserved, not only so that the patient may return to her life as a fully-functioning human, but to achieve optimum benefit from the medical intervention. Why? Because the solutions to medical problems are rarely concise or precise; because rarely is there a single, best treatment; rather, there are options. Which options will yield best outcomes depends largely upon the patient--her willingness to undergo the particular treatment, to cooperate in her care, and give feedback regarding results. Because multiple solutions are possible, and because some solutions are more obnoxious than others, patient input becomes a prerequisite for patient cooperation and, henceforth, success. It must be well understood that the procedures the physician would choose may be widely divergent from those which the patient would choose, for it is the patient who must endure those procedures. As Brody notes:

> "Physicians and patients approach clinical dimensions from different, but hopefully complementary, perspectives. The physician, by nature plays an active role and attempts to aggressively evaluate and manage patient symptoms. From the physician's perspective, the use of technology becomes synomymous with progress. Patients, however, see things differently. They generally evaluate a medical intervention in terms of cost, inconveninence, discomfort, and dysfunction. They are likely to be more risk-aversive and therefore favor more conservative interventions than physicans."[33]

This is not to say that patients do not wish to cooperate, nor that they do not cooperate; rather, it is to say that their motivations differ from those of health care professionals. The patient's motivation must be sought and considered as an essential component to successful therapy. The import of patient inclusion is acknowledged by Fiore thusly: "It is essential, therefore, for [patients] at least

to exercise some form of control over their treatment and hospital environment.... When patients are given a sense of choice and responsibility... they can accept and decide that they want even a painful treatment."[34] Because cure or control of physical dysfunction often requires that a patient get worse before he gets better, that increased suffering precede respite, the choice to undertake the therapy must be the patient's. Only then can she be fully motivated to cooperate with her therapy and to accept and manage the consequences thereof.

The second constraint on autonomy lies in impaired psychologial function. Like physical impairment, the ultimate resolution will come only with control or cure of the illness, but until that resolution occurs, the patient's psychological status will play an important part in the recovery process.

One of the most prominent reactions to being hospitalized is fear.[35] The intensity of the fear may derive from the severity of the illness, e.g., "... there are two parts to every serious illness. One is the illness itself. The other is the panic it produces. The illness and panic are in a state of ominous interaction. Panic adds acute stress to existing disease."[36] However, fear of the illness itself does not solely account for the apprehension and anxiety which patients experience. A 1974 study in which patients were interviewed to determine their causes of anxiety upon admission to a hospital found that 32% of these patients ascribed their apprehensions to the fact that they "did not know what to expect."[37] This response constituted the largest single concern of patients interviewed. This fear of the unknown encompasses the illness, its treatment, the nature

of physicians, nurses, and other patients, and "a lack of knowledge about the new environment and role of patient."[38] Of particular interest is the fact that patients have this fear of the unknown with regard to their physicians. Macintyre notes: "The modern patient... approaches the physician as stranger to stranger; and the very proper fear and suspicion that we have of strangers extends equally properly to our encounter with physicians. We do not and cannot know what to expect of them."[39] This is hardly surprising when one realizes that modern medicine is increasingly becoming the purview of the specialist who operates from an extensive medical complex; viz., the familair (to the patient) family practitioner is seen less and less frequently, patients are often referred to many specialists, and care is thus often fragmented. What is surprising, however, is that the physician continues, in the absence of a long-standing and intimate relationship with the patient, to exercise near-total control over the details of a patient's hospitalization, particularly in the realm of access of patients to information.

When health care professionals knowingly address this source of anxiety, that anxiety is alleviated. As early as 1966, nurses hypothesized that patient education might be the key to reduction of anxiety regarding hospitalization. Therefore Elms and Leonard devised a research project in which patients were given information about hospital routines, what was entailed in diagnostic and treatment procedures, and the patient's illness. As expected, the patients' feelings of anxiety were diminished.[40] The outcome obviously supports

the belief that fear of the unknown in patients is reduced through the provision of information.

The final issue which must be addressed is the tendency for fear to feed upon itself. In the absence of concrete information, the imagination can run rampantly and, as Wilson-Barnett warns, "... if patients are fearful and not given clear explanation of their condition and treatment their fantasies may be even more terrifying than the reality."[41] Thus it may be concluded that in denying patients the opportunity to actively participate in their case, health care professionals not only fail to address a significant component of the patients illness, but may actually contribute to the deterioration of his overall status.

The third constraint on autonomy is imposed by rigid controls placed upon patient access to information, even though the information is about the patient herself. Currently patient access to information is near-totally dominated by the physician, who unilaterally decides what and when patients will be told. Though other health care professionals may reinforce information which the physician has elected to divulge, they may neither initiate information exchange nor respond to patient inquiries in areas proscribed by the physician. Freidson accurately describes the paucity of communication stemming from the physician control:

> "By and large, without medical authorization paramedical workers are not supposed to communicate anything of significance to the patient about what his illness is, how it will be treated, and what the chances are for improvement. The physician himself is inclined to be rather jealous of the prerogative and is not inclined to authorize other workers to communicate information to the patient.... But while he does not want

> anyone else to give infomation to the patient neither is he himself inclined to do so."[42]

Time does not permit an analysis of how and why the physician came to acquaire and continues to maintain such authority. But an examinaiton of the "reasons" given to justify lack of communication is necessary if they are to be refuted.

Brody enumerates four basic theoretical constraints on exchange of information. They are:

> "(1) Patients may lack the maturational and intellectual capacity to receive and process information and make rational medical decisions; (2) patients may also have psychological barriers to the perception and processling of information and decision-making; (3) physicians may believe that presenting patients with enough information to make rational decisions would be too time-consuiming and, therefore, expensive; and (4) physicians may also believe that presenting patients with information about their medical condition will make them more anxious..."[43]

While there may be some justification to the first claim that some patients lack either maturity or intellect to make reasoned choices, e.g., the young child or the mentally handicapped person, these conditions can never excuse a health care professional from imparting the information a patient needs to effectively manage his illness. Rather these seeming impediments serve as a mandate to the health care professional to provide information in such a way that the patient can understand it. In those circumstances where communication with the patient is truly impossible, e.g., infants or severely retarded persons, the information must be provided to a family member or significant other whose familiarity with the patient enables him to make decisions on behalf of the patient.

As to the second alleged constraint, we have already seen that absence of information leads to and/or aggravates a patient's fear of the unknown. Thus further restrictions on communication can only intensify any existing psychological barriers.

The charge that patient education is time-consuming and expensive is true. Yet failure to proivde adequate information is both actually and potentially more time-consuming and expensive. This claim is supported in the literature in wide-ranging studies of patient non-compliance.

Patient non-compliance is the failure of a patient to follow a prescribed medical regimen, and is considered to be one of the major causes of ineffective treatment. Non-compliance rates reported in the literature range from 25 to 50%.[44] Various explanations have been given for patients' failure to comply with recommended treatment, among them an attempt to gain control over the treatment,[45] dissatisfaction with the physician and the medical milieu;[46] patients' perceptions that the health care professionals were not concerned about them;[47] failure of patients to understand their diseases, treatments, and the necessity for continuing treatment;[48] failure of health care professionals talk frankly with patients[49] and to treat the patients as a "worthwhile human being."[50]

Though this lengthy recital gives specific areas of offense, such offenses may all be seen to address the issue of treating the patient as an autonomous person, capable of informed and rational choice. When these patient complaints were addressed by health care professionals, rates of compliance increased significantly, e.g.,

correcting the dissatisfaction with personnel and environment in a hypertension treatment clinic resulted in reduction of the patient dropout rate from 42% to under 4% and the attainment of normal blood pressure in 85% of the patient population;[51] expressions of concern about patients resulted in a 23% increase in compliance in another clinic;[52] while in a third clinic, health care professionals found that the efforts required to educate patients about their "active problems, risk factors, treatment, and health maintenance behavior" not only "minimally adds to the time spent with the patient," but resulted in greater control of hypertension when compared to patients not so involved.[53] Such findings support the contention that the recognition of patient autonomy results in increased patient satisfaction and improved health outcomes.

The final rebuttal against the charge that patient education is prohibitively time-consuming and expensive can be found if one sees the problems of non-compliance through to its logical conclusion: patients who fail to adequately control or cure disease will require more future expenditure of time and monies.

The last alleged constraint, that of incurring fear in patients by sharing information regarding their conditions, simply is not supported by experience. As has already been shown, increased patient knowledge promotes cooperation with health care professionals, increases patient compliance, and decreases the fear and anxiety which attend illness. Furthermore, Stevens, et al. found that hospitalized patients who had unlimited access to their charts not only failed to

display the anticipated anxiety or depression, but were able to objectively monitor their progress. In individual cases communication between patients and staff were facilitated.[54] Thus it becomes apparent that the traditional excuses for withholding information from patients currently have no foundation in fact and can actually precipitate or aggravate adverse patient responses, viz., make the whole patient sicker.

The fourth and final inhibitor of patient autonomy is found in the approaches of health care professionals to patients. Here it is useful to recall the parameters of the sick role, as that role is the basis for medicine as it is practiced today. Briefly, the sick role exempts persons from responsibility; it insists that the patient, who is unable to resolve her illness alone see illness as undesirable, seek and cooperate with technically competent health care professionals, and allow herself to be "taken care of." Clearly, this role is archaic. Patients are now assuming responsibility for their own health maintenance and/or restoration--and are physically and mentally healthier when they succeed. When persons define themselves as ill and seek to restore a more normal health state, they do seek medical assistance and, insofar as they are willing or able, cooperate. But persons are no longer content to be merely "taken care of." Rather, they wish to participate actively in the care process and, again, are healthier because of their participation.

Sadly, recognition of the benefits of responsible, involved patients has been slow in coming to health care personnel. There

are reasons for either failing to recognize or ignoring the need to acknowledge the individuality of patients and their needs. Most prominent is that it is generally thought to be much easier and less time-consuming to treat all "gallbladders" or all "high blood pressures" or all anythings synonymously or to do so, at least, insofar as one can get away with that approach. This method allows health care professionals to develop protocols for care, the implementation of which becomes automatic. Procedures can be quickly and efficiently performed, and routine patient needs can be handled with dispatch. And while it has been shown earlier that this approach is self-defeating in the long run, it does work for the day-to-day, task oriented performances in professions (most notably, medicine and nursing) where demands for service exceed supply. Nonetheless, it is still the case that "[In] negative evaluations of relatively high percentages of patients who took up more time and were talked to...it was found that the patients with whom more time was spent were much more likely toto (sic) be labelled problem patients than those with whom average or less than average time was spent.... In short, the less of the doctor's time that the patient took, the better he or she was viewed."[55] The patient who is not routine, i.e., whose care cannot be handled by protocol, demands other less familiar, hence, more time-consuming management. Or as Duff and Hollingshead observe: "... problem patients obstructed work and no problem patients facilitated work."[56] (emphasis in the original). Lorber further notes that physicians and nurses tend most often to apply the label of "problem patient" to patients with "deviant attitudes," i.e., those patients who fail to conform

to the hospital-patient role."[57] Such patients were described as being more argumentative and complaining than "no problem" patients. To paraphrase, patients who cannot be handled routinely, patients who are not "average" (Recall Jasper's position.), are seen as problems.

Even more distressing than the label is the means by which such patients' needs are managed. Rather than attempting to identify the source of the "problem patient's" distress and to meet those unique needs, the medical profession marshalls its forces to either suppress the discordant voice or to rid itself of the menance. Disruptive patients who display troublesome behavior may be neglected, tranquilized, referred for psychotherapy or discharged prematurely,[58] measures which uniformly meet the needs of the health care professionals, but not necessarily the needs of the patient.

There are many good reasons for condemning this impersonal and unthinking approach. First, because the patient's need is not identified, and because the uniqueness of the patient's body, as well as his personality may not be recognized, the treatment has a high probability of being ineffective and even harmful. But, more importantly, because this approach fails to consider patients as unique human beings, it aggravates and perpetuates the diminished autonomy which accompanies illness; it denies a person's humanity by treating him as an object.

In summary, we find that patient autonomy may be diminshed because of impaired physiological and psychological functioning, lack of sufficient information upon which to base reasoned choices, and inappropriate, counter-production expectations of patients by the

medical system. We have further noted that these restrictions to autonomy can be attenuated or overcome and that therapeutic goals may be more fully realized by providing patients with opportunities for input and by providing patients with information. In other words, the autonomous patient achieves the desired health status more fully and more frequently.

J. L. W. Price asserts, "I believe that the loss of decision-making is probably the heaviest blow of all to most patients' morale."[59] If his assessment is correct, it becomes incumbent upon health care professionals to change the ways in which they provide services. The sick role must be reinterpreted, such that the patient is acknowledged as being an important--in fact, the most important--participant in the therapeutic planning, rather than one who is exempted from responsibility for her health status. Further, the patient can no longer be expected to implicitly trust health care professionals and weakly submit to their recommendations. Rather the patient must be considered as the ultimate decision maker, guided in her decisions by the health care professional who provides the patient with salient data on diagnosis, various methods of treatment, expected outcomes, and delineations of self-help techniques. This necessarily implies as ambience conducive to exchange of information, one in which patients see themselves and are seen by health care professionals as independent agents capable of offering valuable assistance in the attainment of health goals. In the absence of such a humanistic philosophy, the patient is denied the status of personhood and is relegated to the status of an object to be manipulated. Such a status when imposed upon persons, is clearly unconscionable.

NURSING: THE QUASI- PROFESSION

The necessity of change in attitude and action vis-a-vis patients could be examined from the perspective of any number of health care professionals--physician, physical therapist, dietician, respiratory therapist, to name but a few. However, the remainder of this paper will focus on the role of the nurse, past, present and future, how she can be a significant force in the move towards patient autonomy, and recommendations for changing nursing so that autonomy may be achieved for both nurses and patients.

Nursing: A Brief History

The 24th chapter of Genesis makes mention of Deborah, Rebekah's nurse.[60] Her presence is briefly noted; her role is not delineated. She is significant to this discussion only as an indication that nurses have been around for an appreciable length of time.

Since Deborah's time, the nursing profession has experienced not a few growing pains. Searching now to know where we are, perhaps it would be useful to know where we have been.

The word 'nurse' comes from the Latin, "nutrire," meaning "to nourish."[61] Pre-Christian nurses had no formal training; rather, any female member of the family, willing, able, and/or designated by the male head of the household assumed the task of caring for the bodily needs of those who were ill. What was lacking in knowledge was compensated for with tenderness and compassion, qualities which have by no means become obsolete. This unstructured approach to care of the sick continued until 325 A. D. when the Ecumenical Congress

of Bishops, convening in Rome, established the Official Order of Deaconesses. The women serving in this organization came from upper class families and performed in the capacity of visiting nurses, thereby manifesting the Christian ideals of charity and mercy.[62] There was still no formalized program of education, but the need for nursing care had been recognized and was supported by a venerable institution within society. The Roman Catholic Church dominated the realm of nursing for centuries to follow, though for spiritual rather than medical reasons. The human body was considered unclean, an object inspiring distaste, and was attended to for palliative purposes only, presumably thereby enabling those afflicted to transfer concern for and care of their bodies to concerns for and care of their souls.

The Renaissance in the Fifteenth century and the Lutheran Reformation of 1517 introduced profound changes into organized nursing, such as it was. Usurpation of the Roman Catholic churches resulted in closure of their affiliated hospitals. The doctrine of female subordination to their male counterparts was re-emphasized, resulting in women being returned to their home and therin secured. With upper class women no longer available for nursing, less charitably motivated women were pressed into service to fill the by then well-established need. Nursing vacancies were filled by anyone seeking refuge from inclement weather or personal circumstances, and women convicted of crimes were allowed to nurse in lieu of serving their sentences in jail. Personal survival and comfort rather than altruism became the motivation for nursing. Little reflection is required to understand the appearance on the scene of a multitude of "Sairey Gamps,"

the illiterate, immoral, ethically reprehensible creature depicted as the typical nurse by Charles Dickens in his novel Martin Chuzzlewitt. "Nurse" became synonymous with an untrained, unschooled, ill-bred, immoral woman.[63] (What an image and history to overcome!)

Into this long-standing, despicable situation came Florence Nightengale. An English gentlewoman by birth, she defied family protestations to enter nursing in 1851. Her arrival on the Crimean Front in 1854 revolutionized the nursing as well as the medicine of her time, and laid the groundwork for nursing as we know it today. In the face of familial, governmental, professional, medical, and financial opposition, she initiated the concept of total patient care. She demanded and initiated the means whereby "the patient was to be treated as a whole person and not as a disease entity."[64] Under her direction and at her insistence, improved physical facilities were constructed, dietary regimes revamped, laundry regulated, hygiene (personal and environmental). instituted--all in addition to giving the necessary attention to the patho-physiology of the patients. Within six months the efficacy of her methods was verified--the mortality rate in the battlefront hospitals had plummetted from 50 to 60% to 2%.[65]

The war ended but Ms. Nightengale's efforts continued. She returned to England and established the first school of nursing. In so doing, she did not leave her principles of reform on the battle-field. Heretofore nursing education and implementation had been under the auspices of the physicians who were in charge of the hospitals with which nursing was affiliated. This arrangement

made the doctors, in effect, responsible for the development and practice of nursing. Ms. Nightingale demanded and received, albeit grudgingly, autonomy for nursing through her "uncompromising doctrine which insisted on the need for full authority for the matron or superintendent of the school who must be a nurse, not a physician or layman."[66] It was Ms. Nightingale's contention that nurses should educate nurses. Further, she contended that education should serve as a foundation for decisions made, within its scope, by nurses for which they alone would be accountable. In promulgating the belief that there should exist a body of knowledge defined and acted upon by nurses with the results of those definitions and actions being the nurses' responsibility, Ms. Nightingale established the concept of nursing autonomy.

Simultaneously, nursing reforms were beginning in the United States. American hospitals paralleled Britain's in their notoriously deficient state. In the early 1870's an investigation of Bellevue Hospital found prisoners serving out their terms by "nursing." In reality the bulk of these nursing activities was comprised of terrorizing those persons whose misfortune included having been committed to their keeping. The institutions were combination municipal hospitals, poorhouses, insane asylums, houses of correction and orphanages.[67] One cannot help but wonder whose, if indeed anyone's, needs were met by this health care system.

To a large extent, the explanation for such dubious "nursing" practices can be found by examining the nature of the hospital in America and of the "science" of medicine in the 19th century, i.e.,

at the time immediately prior to the inception of nursing as an organized, formally defined practice. Regarding the hospital, one notes it came into being, not as an institution which had as its primary function the care of the sick and injured, but as a mandatory refuge for socially marginal human beings. Thus we find: "Hospitals initially grew up in the 19th century as places for lower-class people, some of whom were ill but many of whom were destitute and felt by families, town fathers, and society to need the supervision of an institution."[68] Certainly they were not instituted to care for the health needs of the upper and middle classes, whose members generally had their medical needs, no matter how urgent or extensive, met in their homes. Nor, for that matter, were hospitals established expressly to meet health needs of their occupants; rather they were designed to supervise (or perhaps, restrict) the activities of those persons society considered to be incapable of functioning acceptably within that society. However, some hospitalized persons were sick and therefore did interface with physicians. Unfortunately for the patients, the state of the art of medicine had little more to offer than the hospital setting. Though there was a body of medical knowledge, it was signally marked by a paucity of understanding of human physiology and of the cause and effect relationship of disease. Indeed, it was not until work like Walter Reed's yellow fever experimentations in 1900 that medicine had been able to isolate causative disease vectors, making diagnosis difficult, if not impossible. And cures, except in self-limiting illnesses, or unrefined surgical cases, had to wait for the discovery of Sulfa in the 1930's and

Penicillin in the 1940's. Physician intervention had either of two characteristics--ineffectual and consisting in the description (popularly attributed to Voltaire) of the physician's amusing the patient while nature healed the body, or actually harmful as described by Conrad and Schneider: "Physicians of the [first half of the 19th century] practiced a 'heroic' and invasive form of medicine consisting primarily of such treatments as bloodletting, vomiting, blistering, and purging."[69] Small wonder that patients frequently, inexplicably, and unpredictably grew better or worse in spite and/or because of medical ministrations.

But the scientific data base for medical regimens expanded. By the end of the 19th century Koch and Pasteur had established the germ theory of disease, Semmelweis' theories for contagion control and antisepsis had been proven to have utility for positive outcomes, and anesthesia had made surgery something less than overt torture. As the science of medicine expanded and physicians gained the capacity to favorably effect outcomes, importance of competent nursing care was recognized. No longer could patients be remanded over to the illiterate, the uneducated and the uncaring. If medicine based on science was to succeed, the nurse at the bedside had to be familiar with those scientific principles, so that the on-going, personal care of patients took into account disease transmission, antisepsis, germ theory, etc. In other words, formal education of nurses became necessary.

On May 1, 1873, the first school in the United States for training nurses opened at Bellevue. Its policies were grounded in the Nightingale doctrines of nursing autonomy. Other unique approaches were instituted, among them the ideal that "... nurses would assume responsibility for their own education and training as nurses. Henceforth their aim would be cooperation with, not subjection to the medical profession."[70] As desirable as this statement of policy may have been, a number of constraints upon nursing and nursing education precluded its realization. To understand nursing's inability to fully realize this goal, one must examine the historical development of medicine and nursing.

In the Eighteenth and Nineteenth centuries, both physicians and nurses were trained under an apprenticeship system,[71] i.e., the method whereby the novice "relies on copying the art of an acknowledged expert in the field."[72] Such an approach teaches how, but not what, why or when. For medicine, this method became outmoded with the emergence, beginning in 1807, of proprietary medical schools, schools which either limited or ignored the clinical aspects of medicine.[73] Thus medical education begin to radically diverge from nursing education, as nursing education had always and continued to emphasize clinical practice.[74] For this reason, schools of nursing had been developed through affiliations with hospitals[75] which afforded the largest, most easily accessible group of patients with variable pathology. By the end of the Nineteenth Century, medicine had come to realize the value of teaching medical students through the study

of patients. The efficacy of the clinical method of teaching was unquestionably superior to the purely didactic approach previously used. Thus affiliations of medical schools with hospitals, clearly seen as advantageous, precipitated a movement of medical education into the hospital;[76] that is to say, into the environment where nursing was already established. Medical schools with access to hospital facilities became the leaders in medical education, and begin to change the criteria which constituted acceptable education. This mandate for change soon included the curricula of nursing schools. The rise of scientific medicine, coupled with its resulting change in priorities for medical education, began to reshape the body of knowledge which constituted nursing. Nursing's apprenticeship form of instruction was not equipped to educate its students in these new developments. Nonetheless, physicians expected--rightfully--nurses who cared for patients to know and act upon recent scientific developments. Hence the schools of medicine began to instruct students of nursing in the hospital programs with which both were allied; viz.,

> "The development of bedside teaching and close affiliations between hospitals and medical schools increased the need for nurses educated to a higher level than formerly. The medical school faculty begin to assume the responsibility for part of the teaching of students enrolled in the nursing schools associated with their teaching hospitals, and the trend has continually increased."[77]

While the educational model for physicians evolved to a combination didactic/clinical format, the basic apprenticeship model for nursing remained largely unaltered. In fact, Stevenson notes that "As late as 1940 in America, nursing was viewed as an art to be conveyed

through an apprenticeship," thus enforcing and reinforcing nursing's subservience to medicine.[78]

This view of nursing also helps to explain the difficulty encountered in realization of nursing autonomy, first articulated by the Bellevue School of Nursing in 1873. For modern--that is, scientific--nursing began under the aegis of physicians, most of whom were reluctant to relinquish their control of the then fledgling branch of medicine. Rather than viewing the assumption of nursing of its personal responsibility with relief or pride, most physicians took a dim view of the effrontery and seeming ingratitude displayed by this attempted unsurpation of power. This evaluation of nurses by physicians has changed little over the last century. Lynaugh and Bates, in their perceptive article, "The Two Languages of Nursing and Medicine," note that nurses share information through "communication" while physicians do so through "orders;" nurses "suggest" while physicians "order;" nurses "collaborate" while physicians "delegate."[79]

It is significant that, once trained, most registered nurses left the hospital setting to do private duty nursing. In 1930, for example, "between 70 and 75 percent of all registered nurses were self-employed as private duty nurses... "[80] The reasons for a nurse's choosing private duty were many and varied; among them were the dismal hospital working conditions of 16 hours a day, seven days a week, the reluctance of hospitals to hire graduate nurses when the forced labor of student nurses was available, hospital salaries which consisted in little besides room and board, and total domination by the hospital of personal life, e.g., curfews, small rooms in which

males were not allowed, bad food, etc. The advantages of private duty, conversely, lay in high degrees of autonomy, described by Wagner:

> "Private nurses enjoyed a considerable independence and skill in their work. As entrepreneurs, they were able to select or reject individual cases, take vacations and breaks at will, and move in and out of the work force. Many private duty nurses enjoyed the responsibility of an individual case. It was rewarding to spend six weeks to three months with one patient: The nurse was able to observe the progress and recovery of the patient, work closely with the family, and feel an integral part of the medical process. She did social work, dietary counseling, physical therapy, operating and surgical procedures, as well as preventive care. Many private duty nurses feared, quite correctly, that hospital employment would mean "mass cure" assembly-line work with each nurse caring for dozens of patients with a loss of control and personal contact with patients."[81]

This system of entrepreneurial nursing might have continued unabated had it not been for the depression of the 1930's. But the widespread economic collapse made the purchase of nursing services (along with many other services) a luxury few could afford. Wagner notes that in 1932-33, the unemployment rate for nurses was 60% and that by 1933 thousands of nurses left nursing for other jobs.[82]

Combined efforts of the American Nurses' Association, concerned about their membership, and the American Hospital Association, concerned about the low quality of nursing care provided by untrained students, succeeded in increasing the number of hospital positions available to registered nurses. But little was done to ameliorate the adverse conditions which hospital nurses were required to endure.

> "By 1941, most hospital nurses still earned less than many private duty and public health nurses and far less than female factory workers. About 80 percent of nurses were still required to live in the hospitals. Three-quarters of nurses had no sick pay, half had no free hospitalization, and two-thirds no pension.

> Broken schedules, artibrary dismissals, unpaid overtime, 50-60 hour weeks and unposted schedules continued to exist for most staff nurses."[83]

The denouement of autonomous, private duty nursing came with World War II. The expansion of hospitals and their increased utiliza- created an even greater shortage of hospital nurses. The general aura of patriotism resulted in a public clamor for nurses to man the hospitals. But the deplorable working conditions therein continued unabated. Nurses who refused to join hospital staffs, either continuing in private practice or leaving nursing, both options being more personally and financially rewarding, were publically castigated for failing to do their wartime duty. Rather than working to upgrade hospital working conditions, the National League for Nursing and the American Nurses' Association, capitulating to pressure to solve the nursing shortages, reinstituted studentlabor, lowered entrance requirements for and duration of education in schools of nursing, and endorsed the creation and use of licensed practical (i.e., non-professional) nurses and nurse aids.[84] President Roosevelt, in 1945, singled out the nursing profession for draft eligibility.[85] Faced with public hostility, governmental intervention, and defection of their own professional organizations, registered nurses succumbed to the pressure and entered the hospital work force. By 1946, the private duty nurse represented only a small minority of the work force. By 1946, the private duty nurse represented only a small minority of the profession.[86] The registered nurse, forced by circumstances into employee status, lost her independence. Nurses became answerable, not to their patient-clients, but to a bureaucratic, institutional hierarchy.

This situation persists, largely unmitigated, today when 70% of all professionally active registered nurses are employed by institutions.[87] If anything, the situation has deteriorated further; nurses now are responsible to at least three well-defined "bosses"--the hospital administration who sets the rules for the institutional work-force, the physician who orders the details of patient care and expects such orders to be executed regardless of bureaucratic obstructions, and the patient whose desires frequently are asynchronous with either or both administrative and physician mandates. To whom is the nurse responsible? Whose needs or desires are to be met when a choice must be made?

In 1970 Dr. Eileen Jacobi assumed the position of Executive Director of the American Nurses' Association. Under her capable leadership, nursing made significant advances. She stressed nursing's necessity for being accountable to the public, rather than to any one special interest group, and promoted the assurance of quality as requisite for professional nursing. Under this philosophy, nursing has established and is implementing its own standards for nursing practice.[88]

This is as it should be, for who is better equipped to define nursing than nurses? Failure of nurses to define the scope and quality of nursing practice or to assume accountability for the provision of well-defined, high quality nursing care leaves the doorway open for assumption of this responsibility by others. And yet this task is so difficult, has been so difficult. For nursing remains,

to a great extent undefined, and it is this lack of definition which is largely responsible for the problems nursing currently experiences.

The Current State of the Art and Science of Nursing

In order to understand nursing's problem, it is necessary to recognize that nursing is a quasi-profession. This is to say that nursing does not satisfactorily meet the criteria by which professional status is granted. These criteria, discussed by Freidson, are grounded in autonomy and include legal protection against encroachment by outsiders, self-determining control of the production and application of the specialized body of knowledge upon which professonal practice is based, and a self-determined code of ethics.[89] The legal protection is obtained through the practice of licensure, viz., unlicensed persons cannot legally engage in the practice of the licensed profession. Members of boards of licensure come from the extant professional population. The production of knowledge is generally acquired from specialized education obtained in a professional school which is segregated from colleges of arts and sciences. Entrance is granted by the profession itself, which also determines the curriculum. Persons not educated in professional schools are not eligible for licensure. The Code of Ethics serves as a statement to the public of the nature of the profession and the committments to service by which the professional is bound. While agreeing with Freidson's criteria, I would add a fourth: Clients, actual and potential, perceive the service provided by the professional as being of a critical nature.

Nursing's difficulties lie, not in the absence of professional criteria, but in nursing's failure to autonomously and purely meet those criteria. Forty-nine of the fifty states now require licensure for nurses to practice. But nursing's boards of licensure are comprised, not only of nurses, but physicians and laypersons.[90] Thus the licensing boards which determine eligibility for licensure, statutes which determine adherence to legally defined nurse practice acts, and approval and supervision of schools of nursing partially consist in non-nurse members who determine, among other things, who will be permitted to practice and how nurses will be educated. Further, board members are not selected by practicing nurses, but generally appointed by states' governors.[91] That professional licensure should be, however indirectly, a political function, is incongrous with the concepts of professional self-direction.

In the educational areas, nursing suffers from the problem of excessive diversity. It is now possible to become a registered nurse by attending schools and/or colleges whose educational duration is of two, three or four years. (Further, licensed vocational nurses, i.e., non-professional nurses, are trained in one year). Obviously, the curricula of these programs are variable; generally, the longer the program, the greater the didactic and theoretical--as opposed to clinical--emphasis. What nursing students learn and, hence, their post-graduate capabilities, is a function of the program they attend. Add to this the post-graduate programs which educate nurse clinicians, nurse practitioners, and doctors of nursing science. Graduates from all these programs are referred to as "nurse." Little wonder that

there exists today a great deal of confusion as to what a nurse is and what a nurse does. Sadly, nurses are among those confused.

Much of this educational ambiguity is a result of nursing's response, historically to social pressure from other interest groups, most notably hospitals and physicians, who dictated selection criteria for students, i.e., how many and what qualifications, and curriculum content.[92,93,94] Further, the continuation of schools which "train" rather than educate future nurses, that is to say, schools wherein emphasis is on teaching tasks rather than principles, perpetuate the apprenticeship model. This method of training, with a minimal foundation for understanding one's actions, can only reinforce nursing subservience.[95]

Nursing has succeeded dramatically in its exposition of its own, self-defined Code of Ethics. Because this Code forms the basis of nursing's bid for autonomy and professional recognition, it will be discussed later.

Finally, nursing needs to significantly revise its image, for nurses have ever been seen as "handmaiden to the physician." This was, once, not only understandable but true if we recall that modern nursing began under the aegis of physicians in response to the changing needs heralded by medicine's scientific advances. This servile image was faithfully perpetuated through nursing's apprentice method of training, and continued, upheld through more modern forces. The Cherry Ames book series, widely read by children for the last 30 years, depicted Cherry Ames, R. N., as the subservient female who

acknowledged the superiority of the male physician. Thus Cherry "... rose respectfully when the physician entered the ward, she always did as she was told, and she was valued by the doctor as 'his' good, concerned nurse."[96] Nor have thirty years of television done much to dispel this image. Situation comedies and soap operas portray nurses as wholesome, all-American girls-next-door, as benevolent, maternal women, as romantic or sexual objects for physicians, but rarely as significant figures in the provision of health care.[97] Whether the nurse is depicted as an "angel of mercy," the "cool hand on the fevered brow," the lustily eager amorous foil to the physician or her male patients is irrelevant, as all these descriptions share a common error: the nurse is seen as an object rather than a person. More importantly, all such portraits fail to relate nursing to health care. Rather, they cast the nurse in the nebulous image of the "woman in white" who evanescently floats through the health care setting, contributing nothing but intrigue for a dramatic story line. All this perjorative publicity notwithstanding, to consider nursing practice as incumbent upon physician prerogatives, or to see nursing contributions to health care as inconsequential is to commit an anachronism. Nonetheless, such images continue to impede an understanding of the critical nature of nursing services.

DEFINING NURSING: THE BASIS FOR AN AUTONOMOUS PROFESSION

The resolution of the aforementioned deficits and inhibitions to nursing autonomy lies within a definition, not current extant, of nursing. To become a viable, autonomous profession, nursing must identify itself to itself and to others. It must delineate those areas, unique to nursing, which will form the basis of nursing education and practice. Put another way, nursing must signify those areas of health care for which it assumes responsibility and for which it will hold itself accountable. As Jacox and Norris warn, failure by nursing to define its scope threatens its survival in this era of profound social change.[98] The possibility of national health insurance mandates well-defined scopes of practice for professions seeking inclusion under coverage of such programs. A definition is necessary if nursing seeks to modify the current health care system, so that other health care professions may understand nursing's potential contributions. But, most importantly, nursing must be defined by nurses and for nurses so that nurses know what it is to be a nurse, so that they may, with assurance, get about the business of nursing. "Nurses need to eliminate outside influences, study their practice, document it, relate it to a theoretical framework and revise and modify both practice and framework until they feel secure in their practice, and know that they are practicing nursing."[99]

Health: The Basis for a Definition of Nursing

The thrust of this definition, whatever its final form, must recognize and speak to the very unique, very special perspective which

has ever been at the core of nursing: the emphasis on the health of the total person. This focus by nursing is attested to by Partridge who notes: "Nursing historically and currently espouses humanistic, holistic, patient-oriented approaches to practice. Nursing education speaks of concern for the whole patient and family, meeting patients where they are, and helping them in self-determined ways."[100] It is supported by Sandelowski who observes: "While the other health professions concern themselves with pieces of people, nursing has as its central core the total person with the context of all the forces that direct him/her to or away from good health."[101] Nursing educator, Virginia Henderson, as quoted by Mundinger, believes that:

> "Nursing's unique function is to assist the individual in the performance of health-achieving activities that the client would perform unaided if the person had the strength, will, and knowledge. In offering this service, nurses provide knowledge, motivations, counseling, and the hands-on therapies needed to regain or promote health. In many ways nurses provide the energy or direction for self-help."[102]

In its emphasis on health, nursing differs greatly from medicine, where the dominant focus is on the disease, its diagnoses, treatment, and cure.[103-106]

It now becomes incumbent upon nursing, if it would achieve autonomy and utility, to build a definition of nursing upon this exceptional perspective. The success of this definition and its implementation will rest, however, in the revision of the nursing education process. Several modifications are in order.

First, nursing must standardize its education. Nurses must be uniformly educated so that all students are exposed to like curricula.

A cogent, well-constructed definition will guide nurse educators in this endeavor. Such a definition has been propounded by Joyce Schmidt, R.N., and reads as follows:

> "In its simplest sense, nursing seeks to promote the autonomy of the individual in conjunction with his/her significant others through the promotion of that individual's definition and valuing of health. Nurses promote health by providing the conditions necessary for its recovery (by direct caring for the sick and coordination of all other members of what has been called the "health care team"), and maintence (by educating the lay public)."[107]

The Definition: A Basis for Change

This definition speaks to those qualities to which nursing has always granted priority: patient autonomy, recognition of the importance of patient and family values in determining health choices, hands-on nursing care, an interdisciplinary approach to health care, and health education. The recognition of these constitutive components of the nursing care process allows nursing to develop and promulgate its own distinct and unified professional curriculum. This curriculum could incorporate the ideals of health and of accountability to patients into the teaching process. It would provide a basis for screening of applicants to schools of nursing and for upgrading admission requirements. Such a definition of nursing with its pursuant changes in nursing education would guarantee, in so far as is possible, able and willing professional nurses who are capable or positively affecting change within the health care delivery system.

But nursing's new directions must move beyond education into practice. Nursing must work to create an atmosphere and environment wherein this well-defined, autonomous nursing approach can flourish. Suggestions within this realm are, of necessity, tentative. Yet the health care system is beginning to experiment with alternative methods for health care provision, and the early results are encouraging. One recent innovation, termed "collaborative practice," bears closer scrutiny. This concept, wherein registered nurses and physicians share responsibility for the planning and implementation of patient care, was conceived by the National Joint Practice Commission, composed of representatives from the ANA and the AMA. Collaborative practice consists of five elements:

1. A committee composed equally of physicians and nurses to make joint practice implementation recommendations.
2. Primary nursing, which is defined as using registered nurses who are individually responsible for patients' comprehensive nursing care with minimal or no delegation of nursing tasks to others.
3. Nurses' individual clinical decision-making within the scope of nursing practice as defined by the joint practice committee and other standards.
4. Integrated patient records that combine observations of nurses and physicians.
5. Joint patient record review to supplement separate medical and nursing audits.[108]

As is noted from these elements, nurses and physicians jointly decide on the methods of implementation for the collaborative practice. Thus nursing would have equal representation in making policy which would affect patient care, and there should be a clear

understanding of the areas of responsibility of all the professionals.

It is important to elaborate on the concept of primary nursing, as it is this style of nursing practice upon which collaborative practice is based. In the primary nursing model, each nurse has a permanent patient assignment, viz, the nurse is responsible for a patient throughout his hospital stay. The nurse undertakes the planning, implementation, evaluation, and revision of requisite nursing care for his patients. Similarly, each patient has his own nurse, a single nurse who he identifies as the person to turn to for his care. Although the primary nurse cannot remain with his patients 24 hours a day, he does give the direct care to his patient while on duty, as well as directing the health-related activities of the personnel who will care for the patient whenever the primary care nurse is off-duty. Together the patient and his primary care nurse plan the patient's care. Mundinger summarizes the primary process as follows:

> "Each nurse has a permanent case load and is accountable for identifying and resolving health problems for those clients. . . . Just as each hospitalized client has his or her physician, so does the individual have "his nurse" or "her nurse". That person, the primary nurse determines with the client the goals to be reached and the nursing care to be provided. The primary nurse also coordinates the medically directed regimen for the team of nursing personnel coming in contact with each client belonging to that primary nurse."[109]

Patient-care planning involves bi-directional communication between the patient and her nurse; thus, the patient has the opportunity to iterate her health goals, as well as any habits or factors in her

life-style which may facilitate or hinder her attainment of those goals. Implementation is smoother, as the patient knows what to expect in the way of diagnostic studies and care procedures, and has ample opportunity to clarify his role, as an independent agent, in these events. Likewise, the give-and-take process of communication expedites evaluation and, if necessary, revision of the regimen. Unsuccessful processes may be reworked or abandoned when it becomes obvious that they are counter-productive for established aims.

Primary nursing is not new. Rather it is a return to the "my nurse" and "my patient" method of nursing practice which existed prior to World War II.[110] Its resurgence has been watched with interest, and the research consistently reports success, measured by increased satisfaction on the part of patients, nurses, physicians and hospital administrators. The advantages which accrue from primary nursing are multivariate. Patients reported that their needs and requests are more consistently and quickly met, that they prefer being included in their care-planning, that their questions and concerns are more satisfactorily responded to, and that events are no longer distressing surprises.[111] Health care professionals note that subtle changes in patients' conditions are more quickly detected, thus more quickly addressed, because the primary nurse is more familiar with the patient.[112]

Increased nursing satisfaction is displayed through higher levels of job satisfaction, reduction in turnover rates of the nursing staff, and a sense of fulfillment which accompanies improved patient outcomes.[113] Ultimately, these factors can be expected to be reflected

through more successful recruitment of nurses into hospitals wherein primary nursing is practiced, and into nursing generally by making the profession itself more attractive.[114]

Physicians report satisfaction because primary nursing does improve outcomes, and because their patients receive better care during hospitalization.[115] Hospital administrators discover that decreased turnover of nurses is economically beneficial. Further a stable satisfied nursing staff gives better patient care which results in patient and physician satisfaction. A satisfied client is one who will utilize the facility (if necessary) in the future. Increased use brings increased revenue.[116] The public relations value of satisfied consumers has additional value to hospital administrators.

Conversely, collaborative practice is very new. To date it has only been tried on isolated units in four hospitals.[117] While it is somewhat risky to extrapolate from the findings of so small a sample, the results reported are as encouraging as the findings for primary nursing. Responses of patients, nurses, physicians and hospital administrators were uniformly positive.

In summary a health care delivery system in which patients and nurses autonomously participate yields improved patient care, improved health outcomes, and greater satisfaction on the part of hospitalized patients and health care professionals. While such results, in and of themselves justify such an approach, they have additional worth for nursing as a profession. They allow

nursing to define its scope of practice for itself and others, and provide a basis for a single, unified curriculum for nursing education.

One final recommendation in the move toward nursing as an autonomous profession remains to be discussed: the suggested inspection, with an eye toward accreditation, of hospitals by the American Nurses' Association (ANA). With nursing defined and with a recommended model of nursing practice identified, it becomes necessary to assure institutional implementation of such a model. Examination by the ANA would encourage compliance on the part of hospitals. Presence or absence of ANA accreditation would serve as a means of public and professional education by informing health care professionals and potential patients that nursing's standards are (or not) met by individual hospitals. Thus these groups would be better able to make informed choices regarding where they will practice or receive health care, respectively.

AUTONOMY IN HEALTH CARE: FURTHER JUSTIFICATION

The critic will ask why it is either desirable or necessary to embark upon so extensive a program of change. One could respond to the critic from a pragmatic perspective: Ample evidence has been presented which attests to the ineffectiveness-indeed, overt malevo-ence-of the present system. But such a response would be incomplete. Rather, one would reply that the very nature of humankind demands the abolition of a system which fails to recognize and respond to the fundamental freedom of autonomy which is inherent in persons. The current health care delivery system denies this fundamental freedom. Thus its elimination is not only justified but becomes imperative from an ethical perspective. And it is on the basis of this perspective that the two major areas of this paper, patient autonomy and nursing automony, interdigitate. For the Code of Ethics of the nursing profession is based upon an ethic of self-actualization, viz., an ethic of autonomy. The remainder of this paper will examine nursing ethics, nursing's Code of Ethics, and the application of this Code to patient care.

A History of The Development of The Professional Ethics of Nursing

Bluntly stated, the professional ethics of nursing is still very much in its infancy. In the early portion of this century, when work was just beginning on a nursing code of ethics, Lavinia Dock received the following advice from a physician: "Be good women, but do not have a code of ethics."[118] His remonstration was based on his observation of the haggling a postulated code of ethics had produced among

members of his own profession. Nursing, fortuitously or perhaps by design, has avoided much of this haggling. Leisurely formulation of the code over many years, accompanied by the input of a great many nurses, has eliminated such discord.

At present a code has existed for over thirty years. Though the first ANA constitution, in 1897, referred to the need for a code, it was not until 1926 that an actual code was propounded. At the time, "A Suggested Code" was presented which stressed the creation of "a sensitiveness to ethical situations and to formulate general principles which. . . create the individual habit of forming conscious and critical judgement resulting in action in specific situations."[119] The suggested code emphasized relationships of the nurse to the patient, the medical profession, other allied health professions, nursing colleagues, and the profession itself. The code was not, however, finalized at that time.

In 1940, however, "A Tentative Code" was presented. . . . The structure and emphasis were much the same, but now included guidelines governing interactions with employers and non-medical persons who had significant relationships to patients (i.e., family members, friends, etc.). Further included were responsibilities of the nurse to herself which stated, "A nurse is to keep herself physically, mentally, and morally fit, and to provide for her spiritual, intellectual, and professional growth. She should institute savings plans which will bring her financial security in old age."[120] This code, intended as a precursory guideline for a more comprehensive code which would follow,

served until 1950 when the first formal Code for Nurses was adopted by the ANA. This Code was re-evaluated and revised in 1960, 1968, and most recently, in 1976.

The Code for Nurses, as it was adopted in 1976 and as it exists today, is an admixture of social and professional ethics, all mention of personal ethics having been deleted in the 1968 revision.[121] Professional ethics are those concerns which reflect the interrelationship of practitioners with clients; the first six statements of the Code for Nurses are of this nature. Social ethics are those areas dealing with the establishment of policy within institutions and societies; the remaining five statements of the Code speak to these concepts.

The Code for Nurses is, to a certain extend and of a certain necessity, abstract. Certainly no code could amass and document all ethical dilemmas which have occurred, nor envision all those which might present. Rather, it serves to alert nurses to those situations which should provoke the practitioner toward ethical considerations, and to provide general guidelines for the practitioner to assist in the ethical fulfillment of her professional responsibilities. The Code speaks to what we as nurses <u>should</u> do, not for reasons of medico-legal protection or convenience, but for ethical ones. That is, the Code defines what it is to be a professional nurse. The necessity of a thorough knowledge of the Code by each and every nurse cannot be over-emphasized. Still to be explored are specific kinds of ethical problems encountered in nursing. In what follows, I will

examine some of these, most predominently the essential nature of the need for nursing autonomy as a method of enhancing patient autonomy.

The Professional Ethics of Nursing: Where We Have Been

Though a nursing code of ethics has existed in varying forms for thirty-two years, the practice of a nursing ethic, as yet, is neither solidified nor even uniformly existent. This is not to say that nurses are not (in keeping with the advice given to Lavinia Dock) good women. Rather, it is to say that the development of nursing has all too frequently not been conducive to the establishment and/or implementation of a moral philosophy which is unique to nursing. It seems appropriate to expand upon some of the aforementioned comments by way of explanation.

As the risk of seeming tediously redundant, I wish to briefly review the historical parallel development of nursing and medicine, beginning with the reminder that modern organized nursing in this country was initiated and fostered by physicians. I reiterate this, not with rancor, but to shed light on some of the lingering misconceptions of nursing. At her inception, the nurse was truly "handmaiden to the physician," spawned by him to assure continuation of patient care and observation in his absence. Because she was, to some extent, the physician's creation, it was only natural that the nurse should turn to him for guidance. It was further predictable that her concept of nursing and its philosophical bias would come from the existent medical body of knowledge. Trained by physicians to meet the needs they assessed for their patients, the nurse was

instructed by the doctor on patient requirements and the technical methods necessary to meet them. Given those circumstances, one can easily understand the near-total incorporation of the physician's goals and ethics into nursing. And such a transference was not, in and of itself, bad. At that juncture neither nursing nor medicine was sufficiently grounded in science to have proceeded much beyond the role of concerned caring. For the many years prior to the acquisition of a respectable body of scientific medical knowledge, physicians and nurses shared the same plight: ineffectual intervention toward the mutually espoused goal of attainment, preservation, and/or restoration of health. Such common goals and problems create strong bonds, the severance of which is not without some psychological trauma. And though nursing had early on verbalized the intent and desire for autonomy, the initial break could be neither quick nor final.

But times changed; nursing and medicine changed with them. As more knowledge was acquired, more outcome-altering intervention was possible. As science progressed in both amount and reliability of knowledge, it became possible to more accurately predict the results of any given intervention. Cause and effect became a motivating force in medical care. For if one can be reasonably certain, through application of scientific principles, of producing patient improvement, should not one intercede? Intervention increased, mandating increasing expenditure of time and effort in delineation and consideration of postulated results, predictable and not, positive and

untoward; in patient observation to alter treatment when desired responses have been achieved or when undesirable changes occur; in forestalling and counteracting complications. Numerous mechanical devices have appeared on the scene, making possible more rapid detection of changes in patients' conditions, adding more parameters which make changes in patients' conditions more quickly detectable, requiring more frequent attention. Observations, whether they be made by man or machine, are nothing less than futile unless they are noted and interpreted, precipitating decisions to initiate, change, or withhold treatment. Suffice it to say that modern medicine and its attendent technology demand a constant, diligent, and well-educated interpreter, an interpreter capable of acting in response to those interpretations.

As the science progressed the logical source of said observers became the nursing staff. Physicians' commitments to a multitude of patients precluded their constant presence at the bedside. The nurse was at the bedside, but many times lacked the skills for interpretation and/or authority to initiate intervention. Quickly, urgently, nurses acquired massive amounts of new knowledge. The cardiac moniter appeared at the bedside and the nurse learned, not only to interpret the electrocardiogram, but which pharmacological agents would alter it. The pathology and dynamics of Infant Respiratory Distress Syndrome were clarified, and the nurse learned the care of the tiny infant, replete with respirator, and the maintenance of precarious acid-base balance. Hearts were opened and repaired, and the nurse

learned the management of invasive monitoring. Burn resuscitation, intrauterince monitoring of unborn infants, and renal dialysis entered nursing's purview. Because of such mastery, it is the nurse, in the acute health care setting, who is most knowledgeable about the patient at any given moment. And it is on the basis of this knowledge that the need for nursing autonomy has become apparent.

Much of the nurse's early instruction as she broke new ground came from her physician colleagues (although this is no longer the case). Institutions began to adopt protocols to permit the nurse to respond to her observations, to take action based upon her judgments. Nursing was finally being granted the responsibility for which it had expressed a desire so long ago. The autonomy, in the fullest sense, however, is yet to come.

The Professional Ethics of Nursing: Where We Are Now

With the pragmatic and mundane responsibilities came the ethical ones. When the nurse had only the responsibility for physician notification, a major concern might merely have been incurring his wrath. When faced with a cardio-pulmonary arrest in a newly diagnosed acute myelogenous leukemia (a rapidly fatal condition), the decision to institute cardio-pulmonary resuscitation is fraught with profound ramifications. Myra E. Levine succinctly summates nursing's new dilemmas:

> "But then came the machines which invested in the practitioner the ability to forestall death and even to defy it. It is possible to prolong life, to provide expensive care to some and to choose them over others, to make

> decisions of living and dying, to make decisions of right and wrong, to mediate issues once forbidden to ordinary mortals. What has been a product of divine will now become a confrontation between people, and the rules which seemed so definitive, no longer comforting or certain.[122]

Nursing has been thrust headlong into a quasi-technocracy which has necessitated rapid and broad assumption of responsibility and acquisition of knowledge. Yet while placing the nurse in the position of the direct and immediate care provider, most institutional environs continue to invest the final authority for decisions with the physician.[123] The hallmark illustration frequently presents in the care of the terminal patient when the physician instructs nursing personnel that the patient not be told his diagnosis. The nurse is left to field the probing queries of the bewildered patient. The first section of nursing's Code of Ethics emphasizes the autonomous nature of humans when it states, in part, "Each client has the moral right to determine what will be done with his/her person. . . ."[124] Should the nurse ignore the patient's right, based on such autonomy, to determine his health future? Can he? Dare he contradict the physician? Dare he not? Yarling speaks to this predicament, defining what he terms "triple jeopardy for the nurse."[125] Even if the physician has elected to withhold the diagnosis for benevolent reasons, he places the nurse in the position of having to lie to the patient, as well as having to lie for the physician. He continues by stating that if the nurse understands benevolence from a reference point of autonomy, he is placed in the untenable position of "having to lie, if she does so,

not out of benevolence, but out of loyalty to the physician, or out of deference to institutional policy, of perhaps just as commonly, out of self-interested concern for the security of her job."[126] Undesirable as this situation is, it is compounded by the amount of time the nurse is required to spend with the patient in provision of daily care. Yarling here adds the third jeopardy:

> "...it is the nurse who, by and large, must live day after day with the deception. She must keep the benevolent lie alive while the patient dies, devising extemporaneous, credible answers to the patient's ongoing questions about this pain and that symptom. The physician's delegation of responsibility for the nurturing of the benevolent lie is a very problematic action from a moral point of view. It places the nurse in the position of being the executor of what is, from a moral point of view, a culpable policy."[127]

The pertinent question which stems from this type of situation is why nurses accept the results of a decision in which they had no voice. Such acts flagrantly disavow both patients' and nurses' autonomy.

By way of getting at an answer, consider the situation in which the physician makes a decision the nurse knows to be inconsistent with the patient's expressed wishes? A nurse working closely and over an extended period of time with a terminal patient may have heard the patient many times express the desire that his life not be prolonged. Yet the physician, bowing to the dictates of her own philosophy or perhaps those of the patient's family, ignores this piece of information and insists that the patient be resuscitated should the need arise. Whose instructions should the nurse follow? To resuscitate the patient is to deny patient autonomy. To accept the results of a decision which one has good reason to question and in which one had no

voice here causes the nurse to violate her duty to her patient. There really should be no question of where the nursing duty lies. "If the nurse has a primary allegiance to the patient, and if the nurse is committed to the moral concept of autonomy, then she must speak up whenever the patient's autonomy is being unethically compromised."[128]

Some persons would yet ask why respect for a patient's autonomy is important; thus we again reflect upon the nature of human beings and their capacity for autonomy based upon reason and freedom. The human ability and right to make informed, rational choices cannot be denied. Yet we do, in fact, deny this capacity each and every time persons are excluded from the decision-making process when those very decisions will affect them. We are, in effect, saying that the person is incapable of rational thought. As such we treat him as a puppet whose care-givers are the puppeteers, pulling his strings at will, making him dance to another's tune. Though it is he who will be most profoundly affected by the decisions, his input is, paradoxically, granted the least (if any) weight. Such an approach is blatantly paternalistic and, as such, imcompatible with a person's status as an autonomous being. With this clarification in mind, the position of the nurse, debating whether or not to resuscitate may be examined.

Failure to resuscitate pits the nurse against not only the physician, but perhaps against the family. (Add to this the spectre of the family's possible disposition to have the validity of the nurse's decision mediated by the courts.) The nurse has only two options: choose a side and suffer the consequences; or ethically cop

out and hope that the death does not occur while she is on duty. The latter option does not postpone the moment of such an ethical collision, since her failure through ommission to act on the patient's behalf and in accordance with his expressed desires must be justified from an ethical standpoint. The same quandry occurs when the family and patient have made opposing decisions, and the physician has extricated himself by failing to support the patient. The nurse, it seems, has no choice except to assert her autonomy and act in such a way that is morally defensible--here, by failing to resuscitate, as the patient requested. Needless to say, it is absolutely essential that the nurse make every effort to assist the involved parties in achieving a consensus. But if a consensus is not forthcoming, the patient's wishes must be upheld.

Unfortunately, however, the increased nursing knowledge and responsibility that require such decisions have not resulted in increased nursing autonomy. And to attain recognition of such autonomy will not be easy as most physicians insist, successfully, upon having the final word in decisions regarding patients' health, even though, as Sandelowski notes, "...They are knowledgeable in only the medical aspects of it. . . ."[129] In this demand, they are supported by most institutions. Such circumstances all too often place the nurse between the devil and the deep blue sea. The nurse can uphold the decisions of the physicians to ignore patient rights and/or desires and wrestle with his conscience. Conversely, he can protect the patient's autonomy and at worst, lose his job; or at best,

field stiff physician disapproval. (He may additionally face resentment of his peers, superiors, and other physicians who, whether they support his decision or not, dislike boat-rockers.) In his uncomfortably perceptive discussion of nurse-physician gamesmanship, Stein chronicles the fate of the nurse who acts autonomously: "The nurse who sees herself as a consultant but does not follow the rules has hell to pay! She is labelled 'outspoken' and usually remains employed but is constantly reminded in a hundred ways that she is not loved."[130] Hence, whichever course the nurse elects to pursue will make his life unpleasant. But only one course of action clearly responds to patient autonomy, and that is action based on nursing autonomy.

To pursue the line of anxiety-producing potential confrontations, consider the plight of the skilled Coronary Care Unit registered nurse. Her education and experience have resulted in an expertise with regard to electrocardiogram interpretation. A patient presents with vague chest pain; an electrocardiogram shows subtle changes of a myocardial infraction. The patient's physician interprets the cardiogram as normal and tells the patient she may go home. At this juncture the nurse can state her diagnosis clearly, resort to Stein's rules for gamesmanship, or say nothing.

Assuming the nurse verbalizes her concern (in one mode or the other), and that the physician maintains the original posture on the diagnosis, the nurse cannot, in good conscience, escort the patient

out the door. She is obliged to take a stand for the patient's protection. The situation must be viewed from the aspect of the patient, as she is surely the one who stands to gain or lose the most from this decision. If she has suffered an infarct and goes home, she may experience one or a combination of the following events. 1) She suffers no ill effects; 2) her symptoms worsen, causing her to again seek medical attention for her now more precarious disability; 3) she misinterprets the severity of further symptoms, fails to seek further medical care, and dies. If she has suffered an infarct and is hospitalized, she has not only availed herself of the necessary medical care, but has improved her prognosis by virtue of early access to that care. If, on the other hand, she has not infarcted and is hospitalized, she will sacrifice (as a rule) two to three days of her time to establish non-infarction, and the funds necessary for reimbursement for the medical care. In the final analysis, it is the patient who has been placed between the extremes of life and death, or of inconvenience and requisite care. Can the nurse dare to usurp the patient's right to make this decision on the grounds that her overriding obligation is to respect the physician's judgment?

I submit that the patient must be given the information that there is a doubt as to the diagnosis; that he must be presented with the alternatives and their attendent ramifications; that his understanding of the alternatives must be assured; that he must be allowed to make the choice for himself; and that his choice must be honored even, and especially, if it is not the choice that the health care

professional would make himself. In short, to assure respect for patient autonomy, the nurse must first (as a logical matter) insist on respect for nursing autonomy. The nurse must insist that his medical colleagues respect the patient's right of access to that information which he may require to make an informed choice, even though doing so may be at the expense of the nurse's own comfort in those ways previously cited.

Such autonomous nursing actions surely need to be supplemented by institutional protocols which delineate methods for patient protection under circumstances of professional disagreement, but they cannot be supplanted by such protocols. Working through an established protocol and its chains of command takes valuable time, which may result in loss (or reduction in quality) of life. In our societal hierarchy of values, human life is highly ranked. The health care professionals should actively pursue those avenues, notably nursing autonomy, which will reduce the error and procrastination which may result in loss of life. Thus on both individual grounds, i.e., an interest in what is best for each individual patient, and on institutional grounds, i.e., an interest in the prompt dispatch of duties to patients as a whole, nursing autonomy ought to be recognized.

This insistence on recognizing nursing autonomy is not a trivial matter, for many nurses have found themselves, at one time or another, confronted with these or analogous conflicts. How do they respond? In 1974 the magazine "Nursing" conducted a poll to which 11,681

nurses responded.[131] Consider our first example of giving patients necessary or requested information:

> To what extent should a nurse explain when asked by a patient?
> As much as possible.....76%
> Only in a general way.....13%
> Only with doctor's permission..... 8%
> Should not attempt..... 3%[132]

Before accepting the polled response, "As much as possible," one must query what specific determinants define "possible." Hospital policy? Ward policy? Physician's known preferences" Nurse's personal conscience? Nature of patient's question? All of the above? None of the above? Thus while it may seem on first inspection that most nurses are keeping patients informed, this has not in fact been established. While nurses are giving patients as much information as they can, how much they feel they can give has not been well defined.

What about situations where nursing autonomy might be a relevant consideration? What do nurses do when they disagree with physicians' orders?

> What would you do if a doctor insists that a patient be given an excessive dosage of a drug?
> Refuse and tell him to give it himself.....42%
> Check with the supervisor and follow her advise.....53%
> Give the drug..... 5%[133]

Consider this last set of options. In the first instance, the doctor may indeed elect to give the drug, thereby harming the patient. Has the nurse in this instance protected her patient? What if the supervisor instructs the nurse to give the medication? The same adverse results would follow as if she had not questioned at all. Supervisory positions are usually granted to nurses who have experience and

who have exhibited expertise, but neither condition assures infallibility. Requesting guidance from one's supervisor, also a nurse, is surely acceptable. But in light of nursing's traditional exclusion from decision-making in the ethical arena, one might wonder if, in this instance, the nursing supervisor would possess the expertise lacking in her subordinate. Yet if nursing autonomy is to be respected, it must be recognized, accepted, and protected throughout the nursing hierarchy. The staff nurse must be free to act autonomously, supported by the knowledge that this approach is considered appropriate and desirable by nursing administration and its representatives.

The Professional Ethics of Nursing: Quo Vadis

The above figures and comments, while they show a need for recognizing nursing autonomy, also show that there is not a solid nursing consensus on nursing autonomy. The factors contributing to this fragmentation are many, though blindness to the need does not seem to be a significant cause. Nurses frequently express the desire for the authority (power, support, etc.) to do what they know/knew needs/needed to be done.

A significant factor seems to be the inability of nurses to make an ethical decision. Let me hasten to add that this inability is a deficiency of nursing education rather than of nursing motivation. Bandman notes: "The vital missing ingredient for nursing participation in ethical decisions has been a theoretical framework which may serve as a reference point for decision-making on a rational rather

than an intuitive basis."[134] It must be noted that logical and ethical reasoning are acquired skills. Yet the teaching of ethics to nurses has not been formally established. Aroskar and Veatch remark that while recent years have seen much attention given to teaching medical ethics in medical schools, "...little explicit attention has been paid to equivalent programs in nursing schools."[135] They continue with a discussion of the report of the Commission on the Teaching of Bioethics (Hastings-on Hudson, N.Y.: The Hastings Center, 1976). In the process of surveying the status of ethics teaching in nursing, questionnaires were sent to 290 accredited United States baccalaureate nursing programs; 86 responses were received.[136] From these responses, it was determined that only six programs required a course in medical or broader-based ethics, though two-thirds reported that "ethical aspects were intergrated throughout nursing courses," with six to ten hours being the average amount of time devoted to the consideration of ethical issues.[137] Aroskar and Veatch point out that such an integrated approach may be incapable of fulfilling the need of giving nurses well-grounded frames of reference for ethical considerations. "If ethics is considered a rigorous discipline in which students should study schools of thought, learn certain facts, and read and reflect on various problems, then a more specific course with well-prepared teachers and curriculum structure is necessary.[138] Yet when the questionnaire inquired whether ethics programs should be further developed, thirty-five percent of the respondents replied that such a need did not exist.[139]

Most nurses are persons of good moral character who wish to do what's right. But nursing has too long labored under the misconception that these qualities are sufficient to assure quality total care for patients. Good intentions do not in and of themselves assure good outcomes. A person may be quite moral, but simultaneously incapable of being ethical. Consider the following distinction between morals and ethics:

> Frequently morals and ethics are equated, yet there are important differences. Morality is generally defined as behavior according to custom or tradition. Ethics, by contrast, is the free, rational assessment of courses of action in relation to principles, rules, conduct. Hence, a person who acts in accordance with accepted, customary beliefs is moral, but to be ethical a person must take the additional step of exercising critical, rational judgment in his decisions. He must ask, "Is my customary behavior right or good?"
>
> For example, in medical practice a principle of patient care is "primum non nocere"--above all, do no harm. A physician who believes in and practices this principle is moral. A physician is ethical, however, if while affirming this principle he is able to look critically at it and recognize that doing no harm may conflict with doing what is best for a patient.[140]

To paraphrase, doing what is usually done is not necessarily synonymous with doing the best job possible, or the most ethical.

If nurses are to cope with ethical questions, it behooves them to know the ground rules. Yet how many nurses are familiar with even the terminology, let alone the procedure involved in an ethical consideration? By way of example, let us examine "rights." We express concern over black's rights, women's rights, student's rights, etc. Bills of Right exist for the handicapped, the child, the handicapped child. In medicine there is, of course, the patient's Bill of

Rights. Yet is anyone really clear as to what constitutes a "right?" Webster variously defines a "right" as a claim, a power, a privilege, and an authority.[141] Fried elucidates this issue by telling us

> "...a right is more than just an interest that an individual might have, a state of affairs or a state of being which an individual might prefer. A claim of right invokes entitlements, and when we speak of entitlements, we mean not those things which it would be nice for people to have, or which they would prefer to have, but which they must have, and which if they do not have they may demand whether we like it or not.[142]

This is to say if we admit a right, as in rights admitted to patients, we accept its provision of fulfillment as our duty. To go further, we may inquire if fulfillment is always a duty, or if exemptions may ever be made. This leads to a consideration of an "absolute duty," (one for which no exceptions can be made) versus a "prima facie duty" (one from which release is acceptable under extenuating circumstances). How does one differentiate between an absolute and a prima facie duty? For example, is the duty to respect a patient's refusal of resuscitation absolute or prima facie in nature?

The preceding is included, not for the express purpose of boggling the mind, but in hopes of illustrating that ethical decisions cannot be resolved by gut-level feelings. The ethical consideration of a question requires certain knowledge and skills which are not uniformly presented to nurses in their educational preparation. Yet nurses in practice come face to face with ethical puzzles, solution of which deems those skills requisite.

Autonomy: The Foundation of Patient Rights

In 1973 the American Hospital Association (AHA) issued the "Statement on a Patient's Bill of Rights." Section 2, quoted below, speaks directly to the issue of autonomy and self-determinism.

> The patient has the right to obtain from his physician complete current information concerning his diagnosis, treatment and prognosis in terms he can be reasonably expected to understand. When it is not medically advisable to give such information to the patient, the information should be made available to an appropriate person in his behalf.[143]

The AHA further elaborates in Section 3:

> The patient has the right to receive from his physician information necessary to give informed consent prior to the start of any procedure and/or treatment. Except in emergencies, such information for informed consent should include, but not necessarily be limited to, the specific procedures and/or treatment, the medically significant risks involved and the probable duration of incapaitation.[144]

The AHA, then, has admitted certain rights to patients confined within institutions. Implicit in this admission is the recognition of patient autonomy as a central principle in medical ethics.

The American Nurses' Association (ANA) explicitly recognizes patient autonomy. In the Code for Nurses, the first section reads:

> "Whenever possible, clients should be fully involved in the planning and implementation of their own health care. Each client has the moral right to determine what will be done with his/her person; to be given the information necessary for making informed judgments; to be told the possible effect of care, and to accept, refuse, or terminate treatment...The nurse must also recognize those situations in which individual rights to self-determination in health care may temporarily be altered for the common good. The many variables involved make it imperative that each case be considered with full awareness of the need to provide for informed judgments while preserving the rights of clients.[145]

Thus two major health care provider groups, the AHA and the ANA, recognize, implicitly and explicity, respectively, the ethical principle of respect for the autonomy of patients. In the admitting of the right, they, and nurses in particular, must henceforth assume the duty of its fulfillment.

Nursing Autonomy: A Necessary Condition for Patient Autonomy

In the preceding discussions of patient/nurse interactions it was illustrated that, in the absence of nursing autonomy, patient autonomy could not be assured. In earlier discussions, it was illustrated that, in the absence of patient autonomy, optimal health care and desired health outcomes were more difficult, if not, impossible, to achieve. It can now be seen that acquisition of professional autonomy by nurses is a status which must be actively sought if nursing is to meet its ethical obligations to its patients. Pursuant to this acquisition is the necessity for nursing to obtain that education which will enable them to competently assume this role.

For nursing to deny that it frequently becomes embroiled in ethical dilemmas is to be out of contact with reality. To admit the existence of the issue but fail to prepare for it is to be irresponsible and, yes, unethical. Nursing has come round full circle to the Nightengale concepts of autonomy. The nursing heritage and patients' needs demand an autonomous profession, for only within that capacity can nursing fulfill its commitments to those it purports to serve.

CONCLUSION

Autonomy, seen to be diminished throughout society, is one of the fundamental freedoms of humankind. It is, in the words of Socrates, "a kind of good which we would choose to possess, not from desire for its aftereffects, but welcoming it for its own sake."[146] While it has been demonstrated that autonomy is desirable on utilitarian grounds, i.e., because of the positive effects it produces, it is, more importantly, good in and of itself. Autonomy is good because, without it, humans differ from the lower species only in appearance; it is good because, without it, humans are not in control, but are controlled. For humans generally, autonomy allows the living of a life of one's own choosing. For patients and nurses, the autonomy permits those choices which make adverse circumstances bearable, which allow persons to rise above circumstances and to be better than they are.

Autonomy does not insist upon recognition; it simply is. In the final analysis, it is the individual who must choose autonomy. Only by so doing will future choices be possible.

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