
Clinical Ethics: Must Nurses Be Forever in the Middle?

by Patricia Murphy

In two senses nursing's role has been characterized as being "in the middle." The first is a historical sense of being trapped in restrictive role definitions, powerless to help patients, families or other nurses. The second is a constructive definition which puts nurses squarely "in the middle" of patient care, dialogue with other health care professionals, and change in the midst of health care reform. It is this second sense of being "in the middle" that nursing should work toward.

Who among us has not complained of being "caught in the middle"? The common view has long held that wavering "in the middle" is the classic form of ethical dilemmas nurses experience:

- Between doctors.
- Between patients and families.
- Between attendings and residents.
- Between "the rules" and creative patient care.
- Between the whole truth and convenient half-truths.
- Between what the patient says when her doctor and family are present and what she says after everyone else is gone.

Yes, much of what nurses experience as concrete, practical ethical dilemmas—"what should I do about this?"—feels like being stuck in the middle. Some of this is a function of the nursing role itself. As the health professional who often spends the most time with a patient, as the one who is only a bedside buzzer away, as the professional whose defining value is caring, as the caregiver particularly educated to help patients come to terms with changes in health status, nurses are naturally, proudly and, one hopes, permanently "in the middle."

There is another sense of "in the middle" that is often part of what nurses mean by that phrase. And this is an awareness that, although it is part of our past, it ought not to be part of our future. I am talking about being caught in restrictive role definitions where one feels powerless to address patient needs. This sense of being trapped in the middle means knowing that something is wrong but not having been taught how to articulate the problem or how to work with others to change a bad policy. This unfortunate sense of being "in the middle" refers to

the explicit or implicit or even subtly internalized rules that say "good nurses don't involve themselves with 'those matters,'" "good nurses don't question authority," "deference is more blessed than assertiveness."

The American Nurses Association (ANA), most schools of nursing, and maturing nurses in countless hospitals across the country are striving to get out of the middle in this negative sense. At the same time, they are reaffirming and enlarging what it means to be in the middle in a creative sense. For example, the nurse who makes sure that she or he is present for the detailed explanation of a proposed surgery and its alternatives to a frightened patient is embracing an appropriate middle position with-

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out any powerlessness or compromise. The nurse on a hospital committee who persuades co-workers in several professions to line up behind a proposed policy change is squarely in the middle in that constructive sense that I hope will shortly characterize our profession. At the same time, that nurse change-agent is helping other nurses and the profession to

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get out of that suffocating middle which, though a part of our history, is not fit equipment for our future.

Whatever the historical and present day structural realities that may have put us in the middle, it is time to admit that it is mostly our self-definition which keeps us there. Being in the middle is largely "in our heads." Nobody will rescue us. We need to get ourselves out of the middle. We should do so because it is a demeaning place for grown-up health professionals, and we should do it because we owe it to our patients and their families. Nurses who perceive themselves as "caught" or "trapped" or otherwise immobilized are in no position to provide others the help they need to cope successfully with alarming changes in health status.

Nurses often feel most compromised, most in the middle, around decision making by and for patients who are critically ill and unlikely to survive. Because nurses are often the professionals in closest contact with dying patients and their families, they can either feel caught in the middle or effectively facilitate good decision making.

What does it take for a nurse to get herself or himself out of the middle and into a proactive and competent stance relative to end-of-life decision making? It takes (1) a robust conception of what it means to be a nurse, (2) some specialized knowledge, and (3) at least some professional support.

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Getting out of the middle and becoming an effective participant in end-of-life decision making requires a view of nursing that emphasizes responsibility and independent judgment. Such role definitions do not have to be invented; they already exist. We need only lay claim to them and use them in our relations with others in the workplace. Most of all we have to internalize them, make them part of our core self-definition.

For example, the ANA *Code of Ethics* should be posted in your nursing station so you can show people how your professional ethics obligate you to advocate respectful treatment for your patient. These are vital notions of what it means to be a

nurse. They are also authoritative, a virtual mandate for not staying stuck in anybody's idea of a powerless middle.

The second part of my prescription for getting out of the middle is that nurses who want to promote sound end-of-life decision making need to equip themselves with a modest amount of specialized knowledge. You should know what the law says and be skeptical of what others tell you the law says; check it out yourself. Attend a good conference. Follow public debates in the press. Study ANA and State Nurses Association documents. Join or stay in touch with the ethics committee at your facility. Ask medical and nursing colleagues to copy key articles that appear in their disciplinary journals and you do the same for them. Developing this kind of knowledge base is not too hard or too expensive. It will be interesting and it will be empowering.

Thirdly, nurses determined to get out of the middle and into a more effective relationship with patients, families, physicians and other nurses need to have at least some professional support. Even as we ought not to wait for administrators or doctors or regulators to free us from constricting role definitions, so we ought not to expect that individually we can buck a system that has a vested interest in keeping us powerless. We need to make common cause with other nurses who share this robust sense of what nursing is all about. We need also to make sure that the nursing leadership in our institution values good people who take responsibility. Since there are plenty of institutions that support strong, capable nurses, we need not stay where the administration prefers warm bodies to responsible professionals.

When patients and families face difficult decisions in an unfamiliar setting, they often desperately need the help we nurses can offer. Whether we are able to help depends largely on how we understand nursing. If we perceive nursing as caught in the middle, then we will feel powerless and be unable to encourage our patients to be responsible decision makers. If we decline to accept self-limiting and demeaning role definitions, then we will be more helpful to those we are pledged to serve and will find nursing a much more rewarding profession.