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# Nursing and Access to Health Care

by James L. Muyskens

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*Nurses have a collective responsibility to become active in current debate on access to health care services. Much recent work in nursing ethics revolves around the notion of nurse as patient advocate. As such it focuses on bedside ethics and the one-to-one relationship of nurse and patient. I argue that in the 1990s, if we are to understand the increasing moral demands upon the nurse, we need a broader perspective.*

*The nurse as patient advocate is too narrow a base for nursing ethics in that it does not do justice to the fact that, in nearly every setting, the nurse is and must be a collaborator and a team player. Furthermore, if all moral obligation is seen as arising from the model of nurse as patient advocate, the collective responsibilities of nurses to work for institutional and systemic change that will improve health and insure greater access are likely to be overlooked.*

In few eras has change been a more prominent feature of all walks of life than the present. The nurse who began practice in the late 1950s or early 1960s and is still active today has seen greater change over her or his career than was seen by the several generations from the time of Florence Nightingale in the 19th century to the mid-twentieth century. Yet the changes of the last several decades may pale in comparison to what is about to occur. Today we stand on the cusp of far more rapid and radical changes in health care.

The interrelated questions that are propelling us toward change in the health care arena are cost and access. Far too many Americans, including children and the working poor, are unable to gain access to health care that would benefit them; they do not have the means, either financial (e.g., they cannot afford insurance) or logistical (e.g., they cannot get to a health center either because of distance or home circumstances).

Among the components of a solution to the current health care crisis will be strategies for reducing costs of many services and bringing care closer to people. Both of these goals will involve nursing in significant ways. For example, many diagnostic tests and routine examinations now done by physicians could more effectively and inexpensively be done by nurses. Moving health care to the people in need—to schools, work places, homes or community centers—will also expand nurses' responsibilities.

Beyond these clear ways in which nurses will be involved in forthcoming changes, nurses also have an opportunity to make a major contribution to

public debate over health care reform and to play a vital role in helping build public consensus. Nursing's involvement in these policy discussions promises to add two essential ingredients: compassion and a dose of reality. The longstanding tradition of caregiving and the practical wisdom of wide-ranging experience uniquely qualify nurses as participants in these conversations. As trusted health care professionals who are privy to the inner workings of all dimensions of health care, nurses have a special obligation to actively participate.

The focus of this essay is how to adjust to this new, urgent moral challenge confronting nurses today. What is required is a heightened sense of the collective responsibilities of nurses and a vivid awareness of the moral imperative for nursing to rally support for reform.

## New Challenges, New Paradigms

The evolution in thinking and in self-understanding required for this task has its roots in recent developments within nursing, specifically the changing ways in which nurses confront and conceptualize ethical issues. I wrote in 1982 about a sense of greater moral urgency in nursing and suggested the primary reason was that we felt far less sure than we had in the past about what ought to be done. I pointed out that what we ought to do is

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determined largely by our roles in society. The nurse's role was in transition and thus there was no clear consensus concerning the scope and limits of responsibilities.

Another factor contributing to the sense of urgency in the 1980s was the difficulty in discerning what we ought to do when faced with the wider

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range of possibilities for patient care made available by new technology. The new situations brought about by technological development required new ways of thinking about moral issues.

Had I been asked in the early 1980s to identify the most pressing ethical challenges nurses face in their practice, a likely candidate would have been those related to new life-saving, life-prolonging technologies. An example:

Nurses are constantly agonizing over cases of clients who suffer from painful illnesses which earlier would have resulted in swift, sure deaths. Now it is possible to keep these people alive with the aid of technology, such as respirators. In many cases, however, the client continues to live but with greatly diminished mental and physical capacity. What ought the nurse to do in such situations to assist the patient? Would it ever be morally right, for example, to "pull the plug"? Sensationalistic reports of nurses who have acted on their convictions that they ought to assist their clients in this way occasionally appear in the newspapers. Sober, systematic reflection on these cases reveals how puzzling they really are (Muyskens 5).

While uncertainty about the nurse's role and adjusting to new technologies remain significant issues in the 1990s, today's discussion of these issues is quite different from a decade ago. Two important developments have changed the context of the discussion: (1) a developing consensus on the nurse's role, and (2) an emerging recognition of limits.

- (1) As a result of a concerted effort by many in the nursing profession, including the leadership of the American Nurses Association, the

nurse's role and responsibilities have been clarified under the rubric of nurse as patient advocate. The "nurse as advocate" has become a generally accepted model for articulating the scope of the nurse's responsibilities.

- (2) As a result of continuing advances in medical technologies and treatments, more and more people are making ever greater demands on the health care system. In the United States, the gaps between demand and supply, need and availability, and cost and ability to pay have widened. Our delivery system and political ideologies have been unable to keep up with advances in technology. The ensuing crisis has cast a pall over the entire health care enterprise.

I wish to argue that nursing has a crucial role to play in the national health care debate. In order to articulate this we need a more robust model than that of patient advocate; one which charts nursing's moral responsibilities both for individual patients and public health.

### **Nurses Have a Collective Responsibility to Become Actively Involved in Current Debate on Access to Health Care Services**

The American Nurses Association's *Code for Nurses* (1976, 1985) states that nurses have a moral mandate to be involved collectively in debates over access to health care. Nurses are directed to work with other health professionals and citizens to promote efforts to meet the health needs of the public.

The ANA's 1980 social policy statement calls for nursing to help improve accessibility to health care. Yet as Patricia E. Stevens has stated in a recent article, "there is little evidence that actions to assure accessibility have entered [nursing's] practice, research, and theory in a significant way" (185). Practice must be drawn closer to principle.

The recent policy statement, *Nursing's Agenda for Health Care Reform*, is explicit in its mission:

We call for a restructured health care system that will focus on the consumers and their health, with services to be delivered in familiar, convenient sites, such as schools, work places, and homes. We call for a shift from the predominant focus on illness and cure to an orientation toward wellness and care (2).

The policy statement notes that nurses are well-positioned to take leadership:

Nurses provide a unique perspective on the health care system. Our constant presence in a variety of settings places us in contact with

individuals who reap the benefits of the system's most sophisticated services, as well as those individuals seriously compromised by the system's inefficiencies (4).

The statement continues by affirming the reasons why nurses must participate in the discussion:

As caregivers in a diversity of settings, responsible for providing care and coordinating health care services 24 hours-a-day, nurses clearly understand the implications of the system's failings. The more than two million nurses in America are at the front lines—in hospitals, nursing homes, schools, home health agencies, work places, community clinics, and managed care programs (5).

Undoubtedly, the determination of nursing to play an important role in the debate is encouraging to the health care consumer. At the same time, this new demand on an individual nurse's time and energy may not be so welcome to her or him. Despite earlier references to these larger social responsibilities, never before have they been seen as so prominent. For any nurse still adjusting to the changes of the 1970s and 1980s, the new demands widen the scope of nurse responsibilities.

A quick review of the changes in our understanding of the root of moral obligation in nursing will illustrate this. From the Florence Nightingale era to the 1970s, nurses' primary obligation was seen as obeying physicians and maintaining order within hospitals. This military sense of nursing identity which Florence Nightingale brought back from the Crimean war established the boundaries for sound practice and discipline. Moral responsibility was viewed as personal, one-on-one. The key issues were:

... loyalty and obedience to the nurse's training school, hospital, and physician's orders; protection of the patient's faith in the physician, even in cases of physician error or incompetence; self-sacrifice under difficult working conditions; and routine indications of discipline such as uniforms and deference to physicians (Bernal, 18).

Many of these expectations were turned upside down in the patient advocacy movement. Instead of loyalty and obedience to the doctor, the nurse's role was to protect patients' rights and interests. The nurse's commitment and self-sacrifice were channelled to advocacy for the patient. In the new era of impersonal, high technology medicine, patients' rights needed protection. Nurses, it was argued, were ideally suited to fill the role of patient rights advocate.

## **The Concept of Nurse as Patient Advocate is No Longer Adequate**

As sweeping and revolutionary as was the change from obedience to advocacy, what is especially important in the current context is that the individualistic emphasis remains constant. While the change from obedience to advocacy was radical in some respects, it represented too little change in at

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least one respect: its continuing focus on individual as opposed to collective responsibility. The new crises facing health care—crises nursing must help resolve—require moving beyond individualistic perspectives on moral responsibility to community values and collective responsibility.

In my own writing about nursing ethics, I have attempted to show how duties to expand access and improve health care delivery can be generated from the notion of nurse as patient advocate. Yet I am now convinced that we need to move beyond patient advocacy, which remains individualistic, to health advocacy, which is communitarian. This is not a rejection of patient advocacy. Rather, I suggest that patient advocacy be subsumed under the larger model of health advocacy.

The view that nurses' duties arise from the obligation to be a patient advocate is unsatisfactory in several ways. Perhaps of key importance is that it fails to take account adequately for the collaborative character of current health care delivery. Providing good patient care in most contemporary settings requires close teamwork by professionals from many different disciplines. Also, advocacy, as typically construed, is unduly confrontational. It sets the nurse apart from other health professionals in championing the rights and welfare of the patient, implying that other professionals do not have the patient's best interest at heart. But it doesn't explain why the nurse is uniquely equipped for the task of standing in for the patient. Is the typical nurse better able than other health professionals to identify ethical issues or uncover threats to patients' rights? Patient advocacy as the fundamental nursing para-

digm can also be questioned in terms of its practicality: Does the expectation that the nurse can advance the patient's cause presuppose greater power to influence policy and procedure than is commonly the case? Can nurses command the resources necessary to make amends when they observe less than optimal care? [For further discussion of the shortcomings of this model, see Ellen W. Bernal's article, "The Nurse as Patient Advocate."]

No doubt the notion of nurse as patient advocate has played a significant role in upgrading the status of the profession. It was a much needed antidote to earlier conceptions which saw the nurse as dependent and subservient. But as we look ahead to challenges of access and justice, and as we reap the benefits of changes brought about by nursing's stronger role and image, it is time to revisit our models of the nurse's role. I propose that we shift from nurse as patient advocate to nurse as health advocate. As such, the nurse is a team player with a unique perspective and essential expertise. This image recognizes that nurses work cooperatively with all members of the health care team, with the patient and the patient's family. It also accounts for the larger context within which health care is delivered and affirms the basic aim of health care, namely, to maintain and enhance health.

The model of nurse as health advocate captures the diversity of setting in which nurses serve. It reflects how deeply nursing is already involved in all the activities that must be expanded as our nation comes to terms with questions of fairness, equal opportunity, and access to health care and related services. Nursing is in the thick of the battles to overcome social, economic and political conditions detrimental to health. Nurses work on the front lines of community and migrant health centers, rural health clinics and public health services. They take a leading role in health services research. At all levels of government they are involved in efforts to improve laws and policies concerned with health.

### **The Nurse as Health Advocate**

The model of nurse as health advocate can bring all the disparate roles of today's nurse under a comprehensive framework that copes with the central issue of our time: making the prospect of healthy living widely available. It builds on the emerging consensus that an affluent society must provide its citizens with the means for healthy living. It builds on the realization that health policy is shifting from treating sickness and finding cures toward health promotion and disease prevention, thereby moving away from a physician-centered approach to a nurse-centered one. Undoubtedly, then, in the com-

ing years nursing's role will advance far beyond that of being subservient or auxiliary. In preparing for this new era, a more expansive conception of nursing's role and greater involvement by nurses in the national debate are needed.

As a society, we have become aware of the importance of maintaining health, preventing disease, and providing care to those whose poor health or age-related infirmities diminish their capacities to function independently. We see that we cannot rely primarily on medical interventions and cures once we are sick. Thus, we are eager for the change that can occur when greater emphasis is placed upon

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those initiatives traditionally identified with nursing.

Nurses form the largest group of health professionals in the health care delivery system. It is nurses who have the special expertise necessary for the new era we are entering. If nursing remains focused on the individual patient and fails to act for the common good, a rare opportunity will be lost—an opportunity for nursing as a profession as well as for the health care consumer. On the other hand, if nursing can organize under the banner of health advocate, it can spark major changes in a health care system that is increasingly under attack as dehumanizing, exploitative and cost-ineffective. When nurses act collectively they can make more of a difference than any other health care professionals.

If nursing rises to this challenge it will be in a better position than ever before to influence public dialogue concerning fairness in health care, and it will be a full-fledged member of the team that forges a societal consensus on questions about allocation. While we might readily agree that the current lack of access to health care for millions in the world's wealthiest country is unjust, building consensus on what justice requires is a more challenging undertaking.

The outline of the ensuing debate with its "point/counterpoint" is already clear. While most of us believe that the government should assure access to health care for those in need, we also feel

that the government is incapable of managing anything in an efficient manner. While most of us believe that health care costs are too high, we also feel that more must be spent on an array of health problems, for example, AIDS, arthritis, breast cancer, spi-

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nal cord injuries. While most of us want to expand access for the uninsured and under-insured, we are unwilling to pay taxes for this.

How we as a nation will resolve these dilemmas is the major philosophical and political issue in health care. Success will require participation by groups from across the political spectrum. More than that, however, it will require informed and compassionate action by nurses, our largest and most essential category of health professional.

### **Conclusion**

The case for nurses' involvement in the public debate over the quality of and access to health care is especially strong: their training and orientation give them an ideal vantage point, both practical and compassionate. In addition, for a variety of reasons,

including the fact that 97 percent of nurses are female, nurses tend to be especially active in numerous non-nursing community roles in schools, religious institutions and civic organizations. As such, more than many other groups, they are likely to know and understand the sensitivities and concerns of their communities, giving them an advantage in building consensus and discovering shared values.

The need to build such a consensus cannot be exaggerated. Current health care reform efforts are doomed to failure if an adequate framework of shared values cannot be found to guide our thinking and serve as a rallying point. Complicating the process is the fact that the older values underlying health care since World War II, such as professional autonomy and patient sovereignty, have outlived their usefulness. A new consensus must be based on communitarian values. The new paradigm will make fair access to health care the priority value. No group is better positioned than nursing to bring us closer to this ideal.

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