
Nursing's Most Pressing Moral Issue

by Terry Pence

Nursing's most pressing moral issue is not a discrete issue such as obtaining informed consent or dealing with the AIDS epidemic, but the more pervasive and basic inability of nurses to practice nursing, that is, to carry out or perform what they believe to be good nursing care. This moral frustration has, no doubt, a variety of causes but the one that I will focus on is the shift in the philosophical conception of the role of the nurse. Historically nurses were trained in obedience and the nurse fulfilled her duty by carrying out orders. Real dilemmas arose when the paradigm shifted in the 1970s, and nurses began to feel that it was the patient and not the physician or the employing institution to whom they owed their loyalty.

Recently the concept of nurses as patient advocate has come under greater critical scrutiny; now some nurses (and others) are giving second thoughts to this role. The burden of this paper is to defend the nurse as patient advocate from these criticisms. In the course of this defense I will give a rough approximation of what the concept means; why I think advocacy's ascendance as a moral metaphor is a major turning point in the history of nursing ethics with profound policy implications; and finally I will catalog and respond to the criticisms of the concept.

Historical Overview

What is nursing's most pressing moral issue? This question has been raised in the nursing literature before, and it is instructive to note what has been said. Twenty to twenty-five years ago a strong case could be made for sexism, particularly as it relates to the doctor-nurse relationship, as nursing's most important problem. Indeed, it was 1971 when Virginia Cleland published her now classic article, "Sex Discrimination: Nursing's Most Pervasive Problem."¹ Leonard Stein had published his infamous "The Doctor-Nurse Game" only four years earlier.² The game described doctor-nurse communication in which the nurse was to make recommendations to the doctor in the guise of questions and hints so that the physician could maintain the appearance of omniscience. One of the factors that perpetuated this demeaning game was the sexual identity of the players: dominant male physicians and submissive female nurses. When Stein and colleagues had the opportunity to revisit this issue in 1990, they noted that there are some changes in the doctor-nurse relationship but the sexual identity of the players was not even mentioned as a factor.³

As a pervasive problem I think sexism has receded somewhat in importance.⁴ What may be responsible for this probably has more to do with the ferment in nursing about what nursing is which began in the 1970s than any real lessening of sexism

in nursing. To illustrate this point, consider the responses of four nursing leaders and educators in the inaugural issue of *Advances in Nursing Science*, when asked to identify nursing's most pressing ethical problem. Although verbally different, their responses were remarkable in that they focused on a central issue. All agreed that the biggest problem would not be the sort one could discover through a survey of practicing nurses. Rather there was something more fundamental going on. Mila Ann Aroskar styled it in terms of establishing to whom the nurse is accountable; Sally Godow focused on defining nursing and the ideal nurse-client relationship; Edna L. Neuman said that it was the failure to see ethical problems as nursing problems (rather than, say, medical problems); and Gino Giovinco simply said it was role definition.⁵

More recently Aroskar has conducted a survey of the ethical issues faced by 309 community health nurses.⁶ The results were grouped according to the moral principle involved and so no one moral problem was singled out. It was significant, however, that many conflicts involved issues of patient autonomy and "close to half complained of a lack of administrative support for establishing and

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maintaining a working environment that enhanced quality patient care."⁷

It is my thesis that what was identified as nursing's most pressing problem in 1979 remains so today. I agree that nursing's most pressing problem is not a discrete issue such as informed consent or dealing with HIV. Rather my candidate is the more pervasive and basic inability of nurses in institutional settings to practice what they take to be good nursing care. That is, there is a moral ideal of what the nurse-patient relationship should be and a frustration that this is not being met. In saying this I believe I am echoing what is sometimes expressed in the nursing literature and by nursing students I encounter.⁸

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This moral frustration has, no doubt, a variety of causes, but the one I wish to focus on is the shift in the philosophical conception of the nurse's role. Historically nurses were trained to be obedient and the nurse fulfilled her (but sometimes his) duty by carrying out orders. The paradigm shifted in the 1970s and nurses began to feel that it was the patient and not the physician or the employing institution to whom they owed their loyalty.⁹ It was then that real ethical dilemmas arose for nursing. The nurse could no longer allow substandard care to pass in good conscience. Not, that is, if nurses are patient advocates. The complaint that nurses are unable to practice nursing is directly linked to the role conception of patient advocates.

As Gerald Winslow has pointed out in his excellent article, "From Loyalty to Advocacy: A New Metaphor for Nursing," the new view of the nurse as patient advocate was hardly opposed at all among nursing educators and in the nursing literature as a whole.¹⁰ Indeed, nursing researchers began to note significant shifts in the way that practicing nurses approached ethical problems.¹¹ The nurse as patient advocate captured the imagination of nurses and was a guiding principle in the ANA *Code for Nurses*.¹² More recently, however, the concept has come under greater critical scrutiny. Now some nurses are giving second thoughts to the concept of the nurse as patient advocate. The burden of

this paper is to defend the concept of the nurse as advocate against these criticisms.

In the course of this defense I will give a rough approximation of what the concept means; its policy implications; and finally I will catalog and respond to the criticisms of and alternatives to the concept.

The Concept of Advocacy: A Core Meaning

Nursing's real moral problems began with the emergence of the model of patient advocacy that placed the nurse's primary allegiance to the person in need of nursing care. As long as nurses were socialized to be handmaidens of the doctors (or as one early nurse said, "simply an intelligent machine for carrying out his [doctor's] orders"¹³) the primary moral responsibility was obedience. But if nurses were more than intelligent machines they would have to be accountable for their actions; they would have some ownership of ethical dilemmas, and they would establish a new nurse-client relationship. As Winslow attests there is a need to clarify what it means to be a patient advocate since it is used in a variety of ways in the nursing literature.¹⁴ What is common to the sort of advocacy expressed in the ANA *Code* and in some of its more thoughtful expressions is a primary commitment to the patient and the protection and enhancement of patient autonomy.¹⁵ There is an explicit rejection of the paternalistic notion that the patient's own good can be defined apart from his or her values and preferences. The *Code* says:

Since clients themselves are the primary decision makers in matters concerning their own health, treatment, and well-being, the goal of nursing action is to support and enhance the client's responsibility and self-determination to the greatest extent possible. In this context health is not necessarily an end in itself, but rather a means to a life that is meaningful from the client's perspective.¹⁶

Each nurse has an obligation to be knowledgeable about the moral and legal rights of all clients and to protect and support those rights.¹⁷

The nurse's primary commitment is to the health, welfare, and safety of the client. As an advocate for the client the nurse must be alert to take appropriate action regarding any instances of incompetent, unethical, or illegal practice by any member of the health care team or the health care system, or any action on the part of others that places the rights or best interests of the client in jeopardy.¹⁸

To be sure, this sketch of the core concept of advocacy leaves unsettled some controversial issues such as whether the nurse's own values may properly enter the professional-client relationship; the extent to which the nurse must go in whistleblowing; and the relative primacy of the obligation to protect clients. Nevertheless this notion adequately reflects common elements in most variations of advocacy and carries with it the weight and authority of enshrinement in the ANA Code. What is less obvious, however, is the power of this concept to suggest bold new ethical stances for the profession. The most provocative examples of the implications

Patient advocacy is a moral idea that requires reform in the system.

of the concept of advocacy come from the writings of Roland Yarling and Beverly McElmurry.¹⁹ They claim that once this new vision of the nurse-patient relationship is appropriated it becomes clear that there are enormous institutional obstacles to its enactment in the hospital. In their words, nurses are "not free" to act as a patient advocate because doing so often pits the nurse against powerful physicians and the economic or bureaucratic interests of the hospital. Nurses must therefore often choose between their professional career and acting on behalf of patients.²⁰ Enacting the ideal of patient advocacy requires reform on several fronts. Not only should there be an issue by issue discussion about such issues as who writes "do not resuscitate" orders, pain management, informed consent procedures, and the use of placebos, there also needs to be reform of the health care system thereby fostering greater professional autonomy for nurses.

The Critique of Patient Advocacy

In 1984 Winslow wrote that he was aware of only one significant essay critical of patient advocacy by nurses.²¹ There were others but since that time criticism has persisted, especially since the publication of the articles by Yarling and McElmurry.²² They have spelled out various practical implications of this model and have become something of a lightning rod for criticism. The United Kingdom Central Council for Nursing's (UKCC) publication of the *Code of Professional Conduct* in 1983²³ set off a debate about advocacy in that country too. The UKCC Code

contains language on advocacy that mirrors the ANA Code.

Advocacy has been criticized for being too idealistic; requiring more independence from the system than nurses have; and destroying collegiality and teamwork on the health care team by its adversarial style. Let's consider each of these.

The first says that patient advocacy is too idealistic. It cannot work because nurses lack the power or the will (maybe both) to act as patient advocates. The consequences of acting as a patient advocate can be severe, as already noted. One British nursing student has written:

I am aware that most readers will be able to bring to mind incidents where a senior nurse has played patient advocate; but this is not habitual or expected practice. The fact remains that most of us are exhausted and demoralized by the daily grind, and simply have not the courage or the will to defy a system which has so effectively socialized us to fit its needs.²⁴

At first blush this criticism hardly seems to be a moral objection to patient advocacy. Rather it seems to be a cynical capitulation to cowardice. The objection rationalizes making patient welfare subordinate to career advancement or job. There is, however, a less self-serving way that this objection can be stated. One may simply argue that patient advocacy is beyond the call of duty if it is too costly to the nurse's career or job interests. For example, older texts on nursing ethics from the Roman Catholic tradition would excuse a nurse's cooperation in immoral activities if the nurse was threatened by some grave consequence such as a loss of job if the nurse did not go along.²⁵ Accordingly, patient advocacy is not the duty of the nurse where there is sufficient hostility to it. Patient advocacy would become a supererogatory act. Nurses who act as patient advocates and run the risk of losing his or her position as a result are to be morally *admired*, but such risk taking is not morally *required* of nurses.

There are two reasons why I do not believe this apologetic for acquiescence to substandard care is convincing. The first is that nursing is a profession in the sense that nurses are given certain exclusive privileges by the public in exchange for their services. Nursing fails in its obligation to the public if it resigns itself to substandard care.

The second is that this defense of the status quo in nursing is precisely what the patient advocacy model wishes to ameliorate. It is a moral ideal that requires reform in the system. Given the special ob-

ligations that nursing has to the public, it is a failure of duty to preserve the status quo due to intimidation.

Another objection to nurses as patient advocates is the claim that nurses are part of the system and therefore not sufficiently disinterested to plead the interests of patients which may conflict with their own.²⁶ One of the earliest proposals for patient advocates, by George Annas and Joseph Healey, championed their independence.²⁷ Nevertheless, before concluding that an entirely new professional was called for, Annas suggested that nurses had the potential to play this role.²⁸ In an ideal situation advocates would be financially independent professionals, but it is difficult to imagine that they would have the medical knowledge or the intimate, prolonged contact with patients that nurses do. The answer to this objection rests in what it means to be a professional. If professional codes are worth anything, then when a nurse takes a job he or she comes equipped with a set of professional values that cannot be negotiated away as part of an employment contract. It would be like asking a professional accountant to cook the books out of loyalty to the company. Professionally they cannot. Loyalty to the company has prescribed limits. Nursing codes proscribe certain acts that an employer cannot negate. Professionally, then, protecting patient autonomy and the nurse's role in the system should not conflict.

A third criticism is that patient advocacy undermines teamwork or collegial relations because it is confrontational.²⁹ This criticism may be based on some caricature of the demands of advocacy. Nothing in the advocacy literature demands that tact or diplomacy be abandoned, and it would be sexist to think that assertiveness on the part of females is unacceptable or unfeminine.³⁰ On the other hand, this criticism may be code for the sacrifice of patients' interests for the sake of collegial relations. If not, then the proponents of this position need to explain how the less "adversarial" are going to preserve the rights and interests of patients.

Alternatives to Advocacy?

Although I do not think any of the above critiques of patient advocacy are substantial, they could gain additional weight if some better model for nursing were available. There are at least four discernable options mentioned in the nursing literature: (1) return to the traditional model of nurse subservience; (2) join the market forces aiming to increase profits as a means of producing happy customers; (3) let someone else do patient advocating; and (4) try some other model of nurse-patient rela-

tionships. However, I do not think these are preferable alternatives. Here is why.

Nearly no one supports a return to models where the nurse's primary allegiance is to a physician or employing institution. Still, philosopher Lisa Newton has written in support of what she calls the "traditional nurse."³¹ What she fears is that if nurses become more autonomous and more powerful, then patients will lose the only humanizing element in the otherwise coldly mechanical, bureaucratic monster that modern hospitals have become. Newton believes that it is frequently only the powerless and submissive nurse who brings sympathy, reassurance, tenderness and warmth to the hospital. Since to be professional is to be objective and in control of one's emotions, becoming professional would destroy this last remaining reef of emotional solace. Further, Newton believes that if nurses actually had the power and authority to act on patient complaints, patients would be frightened by it and therefore unable to use the nurse to let off steam. She also believes that if nurses were autonomous professionals this would make hospitals inefficient in preserving health and saving life. She believes that obedience to orders is required in bureaucratic settings, especially emergency situations—too many generals and not enough soldiers.

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I have not found any critic of patient advocacy willing to follow Newton.³² The assumptions in her arguments—that expression of emotion is incompatible with professionalism, that the public does not want to complain to persons who may be able to do something about it, and that only physicians have the requisite knowledge and skill to restore health and save lives—are highly questionable, if not patently false.³³

Another supposed alternative is to let market forces take care of patient needs. If nurses would only drop the adversarial stance of patient advocacy, become team players and support the profit motives of institutional administrations, then pa-

tient interests will be taken care of in the bargain. One nurse has written:

[T]he goals of doctors, administrators, and other health care personnel aren't actually different from ours. A hospital can survive only if it attracts patients, and patients won't be "satisfied customers" who come again unless they receive good care. Doesn't that common goal make us all advocates?³⁴

I think it is easy to see that this is an overly optimistic view about the power of the invisible (and beneficent) hand of capitalism. It is far too transparent that hospitals want *paying* patients, not indigent ones. And they would like it just fine if patients with diseases others do not wish to be around would seek treatment elsewhere. But both of these attitudes are violations of the ANA Code which bases care on the basis of need alone. As a consumer would I be more satisfied with a hospital nursing staff that is unequivocally dedicated to patient interests or to a staff primarily concerned about the corporate bottom line? Ironically, patient advocacy may be in the interests of business.³⁵

A third alternative is to place the business of advocacy somewhere other than nursing, either on the patient or an independent advocate. This is often coupled with the criticism that nurses have too many conflicts of interest to be patient advocates. No one wants to leave patient rights and interests totally without protection. Phylidia Brown, the student nurse quoted earlier, believes that patients should be their own advocates and that nurses should only play the role of "facilitator."³⁶ Allmark and Klarzyinski recommend that an independent system of patient advocacy be established.³⁷

These suggestions, it seems to me, are based on false assumptions about patient advocacy and present a false dichotomy. Brown seems to think that advocacy is some sort of paternalistic imposition on patients, but both the ANA and UKCC Codes make it clear that advocacy is about empowering patients to make their own informed decisions. A similar misunderstanding can be found in Allmark and Klarzyinski. They think that nurses cannot advocate for any decision they disagree with.

An advocate should plead someone's cause as the person, and not the advocate, sees it. If a liberal lawyer pleads the cause of a neo-nazi group to have freedom of speech then this is true advocacy. A nurse is unable to do this. . . .

Where nurses see detention, gastric lavage and a ban on alcohol as being in the patient's best interests, they will no longer plead their cause. . . .

Nurses cannot plead a patient's cause, only his/her best interest which will be dependent on the nurse's notion of health and not necessarily the patient's.³⁸

Again, this conflicts with the core definition of advocacy cited above. Respecting a person's autonomy does not imply agreement with the person's decision.³⁹

More importantly, citizen advocacy programs and nurses acting as patient advocates are not mutually exclusive. As some nurses have noted, one need not abandon the nurse as advocate to welcome citizen advocacy programs.⁴⁰ Moreover, even under an ideal system it is hard to imagine advocates who are not part of the health care team as having the proximity to the patient, medical knowledge, and awareness of the medical milieu possessed by the bedside nurse. The effectiveness of any such independent advocacy system will greatly depend upon the cooperation of nurses. Independent advocacy could augment but not replace nurses acting in this role. Certainly the existence of such a system would not permit ignoring violations of patient rights and interests.

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A fourth alternative is to find another model for nurse-patient relationships. The most seriously proposed is to substitute covenantal relationships for patient advocacy. The notion of covenantal relationships is derived from the work of William F. May⁴¹ and most extensively applied to nursing by Stenberg,⁴² Cooper⁴³ and Bernal.⁴⁴ Bernal, following May, describes covenantal relationships as having three elements: (1) an exchange of gifts; (2) an exchange of promises; and (3) an ontological change in the parties to the agreement. It is not clear how seriously this formula, drawn from Biblical sources, is meant to be followed; the important point is that professional privilege is given by the public in exchange for the promise of nursing services. The promise that the profession makes to the public in exchange for professional privilege constitutes the basis of the nursing ethic.

Proponents suggest that the model of covenantal relations is more adequate than patient advocacy because nursing promises more than just the protection of patient self-determination. Nursing also includes prevention of illness; promotion, restoration and protection of health; alleviation of suffering; care for the dying; advancement of nursing research.

Since proponents agree that protecting patient self-determination is "essential"⁴⁵ and institutional reforms are needed and long overdue,⁴⁶ the best that can be said for the covenantal model is that it is broader in scope than the patient advocacy model. I think it is a misunderstanding of patient advocacy to claim that it is limited to patient self-determination, but whether it entails these other nursing functions (although I think it can) is a matter of indifference. Supporters of the covenantal model face the following dilemma: either it embraces patient advocacy, in which case it is silly to criticize something your own theory embraces; or it is willing to subordinate patient interests to something higher, in which case it is difficult to understand why this would command respect from the public who may be sold out.

It seems to me that a retreat from patient advocacy would leave the public interest less well off.

How will the interests of patients fare under a covenantal model? I do not think the position is clearly enough stated to figure this out exactly, but their criticism of patient advocacy is somewhat instructive. Bernal thinks that "The adversarial stance of the advocacy model may not be the best way to achieve needed change."⁴⁷ As noted by reference to Yarling and McElmurray, Cooper and Bernal decry the calls for greater autonomy for nurses. They choose to look on the sunnier side of what nurses can do rather than the institutional restraints on what they can't do.⁴⁸ They point out that professional autonomy and patient interests need not coincide. This is true, but proponents of patient advocacy are clear about the connection under their proposals.⁴⁹ It is not apparent how the covenantal model is going to achieve similar ends using different means. If patient interests are better served by greater nursing autonomy (in my opinion this is true), it is incumbent upon the backers of the covenantal model to show how their reticence to be

adversarial (if necessary) or their hesitation to push reforms in the health care system is better for the public or the nursing profession.⁵⁰

Conclusion

Nursing seems to have created a dilemma for itself when it shifted its loyalty squarely to patients in the 1970s. The problem was that nurses met enormous institutional barriers to acting as patient advocates. The concept of patient advocacy has developed a potent reforming social ethic calling for greater nursing autonomy as a means of fulfilling its obligation to protect the rights and interests of patients. I have attempted to survey the major criticisms of patient advocacy and alternatives to it. I find none to be ultimately persuasive or viable. The major touchstone for me is how patient interests would fare if the various criticisms and alternatives were accepted. It seems to me that a retreat from patient advocacy would leave the public interest less well off. That is, patient self-determination is not well served by making the nurse's primary loyalty other than the patient, or by shifting the responsibility for protecting the patient's interests to the patient and/or some other system of advocacy such as friends, volunteers, or a professional advocate. Even if such systems were available they would be even more effective if nurses were not to abrogate their role as patient advocates. The covenantal model, while expressing reformist goals similar to patient advocacy, is not well articulated enough to make a judgment about its effect on patients' interests.

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33. For expanded criticism of Newton's argument see Pence and Cantrall, 2-3.
34. Pagana, 51.
35. A similar claim is made for patient representative programs. See Nancy McDonald, "Patient Rep Can Be Viewed as a Fiscal Asset," *Hospitals* 54 (May 1, 1980): 44, 47.
36. Brown, 26.
37. Allmark and Klarzynski, 35-36.
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46. Bernal, 22-23, and Cooper, 49.
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48. Bernal, 21, and Cooper, 49.
49. See, for example, Yarling and McElmurry, "Rethinking the Nurse's Role in 'Do Not Resuscitate Orders,'" and Webb, "Professionalism Revisited."
50. Allmark and Klarzynski, although not advocates of the covenantal model, go so far as to imply that proponents of patient advocacy are really only interested in using patients rights as a pawn in the power struggle with medicine and as part of the empire building schemes of nursing, 350.