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The ethical dilemmas confronting health professionals have such broad relevance and complex ramifications that they tend to be perennially present. Health professionals have always had to make ethical decisions regarding patient care; however, our era differs from the past in several important ways. Not only do we have more factual knowledge, but we also have developed technology which gives us the mechanisms to implement this knowledge. The combination of knowledge and technology has led to increased power over human minds and human lives. Importantly, the rapidity in the development of new knowledge and technology makes apparent the relative nature of what we consider ordinary or extraordinary health care measures. Very quickly, penicillin and pacemakers ceased to be considered extraordinary measures, to give but two examples of knowledge and technology which we now take for granted. These rapid developments have made ethical issues in the health sciences more difficult to cope with, more relevant, and more urgent. As science has provided the tools enabling us to have greater mastery over life and death, we — both health professionals and the general public — have raised questions which, while going beyond the issues of life and death *per se*, are intricately woven into their fabric. The mass media reflect these concerns in the use of such phrases as, "quality of life," "heroic measures," "right to die," "right to life," "right to health care," "right to treatment," "right to refuse treatment."

Building on accumulated knowledge, especially from the 17th through the 19th centuries, advances in medical science and technology have progressed triumphantly during the 20th century. In the wake of this progress, two sets of major problems related to optimal

health care have arisen. The first set of problems revolves around the adequate distribution and availability of health care and the second set around the danger of becoming so infatuated with the technological dimensions of health care that we cease to question its limitations. More specifically, this means that we can unintentionally lose sight of the axiomatic foundation of health care which is that human beings cannot be understood only in mechanical terms.[1]

The health sciences make many demands upon the abilities, special training, and character of their practitioners. One of these most basic demands requires that we be guided by moral considerations. One of the major difficulties in ethical discourses is that no definite, clear-cut answer exists for all ethical dilemmas. Furthermore, this difficulty is made more complex by the inherent strains in an irreducibly pluralist society. For these reasons, critical reflection becomes necessary in any attempt to deal with an ethical dilemma.

A concern with ethics has formed a theme throughout the long and checkered history of nursing as it moved through time and space from the early hospitals established in India before the birth of Christ, to the religious orders of Europe, to the secular nurses of the Industrial Revolution depicted in the Dickens' character, Sairey Gamp, to the beginnings of modern nursing in the latter half of the 19th century. Historically, at times ethical considerations have been a major theme, while at other times they have constituted a minor theme in nursing since the place accorded these concerns within nursing reflected the complexities and preoccupations dominating the larger social order at a given moment. So, ethics *qua* ethics in nursing is not new, but, as with medicine, both the content and magnitude of the issues addressed have changed over the years. In this era of renewed major concern regarding ethical issues in health care, the issues confronting nursing have received only limited consideration. In part, this situation stems from the paucity of concrete data systematically gathered to document the major ethical issues confronting nurses. Furthermore, the multiple functions performed within the nursing role compound this problem. The comments which follow serve to raise questions as to the nature of some of the ethical issues confronting nurses practicing in hospitals. The decision to limit the discussion to hospital nurses is predicated on the fact that over 70% of all nurses employed work in this setting.

The Hospital Nurse and Ethical Dilemmas

One of the most interesting factors, both from a sociological and from a moral perspective, of hospital nursing is the potential problem of conflicting loyalties. Until around the time of World War II, many, if not most, nurses in hospitals worked as private duty nurses and received a fee for service from the patient. A number of economic and

social factors converged in the 1940's and a shift away from private duty to hospital employee status occurred. Whereas previously the nurse's first obligation was clearly to the patient, now the situation has become more complex. As a hospital employee, she must balance loyalties to the institution, to the attending physician and the house staff, to the patients themselves, while at the same time, attempting to perform according to the ethical codes of the nursing profession developed by the American Nurses' Association. Although no recent research has been noted on this problem of potentially conflicting loyalties *per se*, some few years back research findings indicated that nurses felt major loyalty to the institution where they were employed and not to the patient or to the ethical ideals of nursing. In January, 1977, the *New York Times* reported the results of a national survey in which 10,000 nurses responded to a questionnaire.[2] Of the 10,000 total sample, 3,800 said that they would not want to be a patient in the hospitals where they worked. Furthermore, 18% of the respondents said that they knew of deaths caused accidentally by nurses, and 42% said that they knew of deaths caused by doctors. It is not in the nature of surveys to go into depth as to the meaning of such findings; however, it would seem reasonable to assume that any number of ethical issues could be identified in the situations which have led to fairly widespread dissatisfaction among hospital nurses. In response to the survey, the president of the American Hospital Association said that if nurses were that dissatisfied, ways must be found to enlist their efforts to improve the care they are involved in and hospitals must find more and better ways to get nurses involved in decisions regarding patient care.

Often ethical issues evolving from conflicting loyalties only surface and become explicit when a conflict arises, such as a conflict of opinion regarding the right action in a given clinical situation. The definition of "right action" can be from the perspective of what is right or best for the patient; what is right or best for the physician so as to avoid a malpractice suit, for example; or what is right or best for the hospital. What is morally right for the nurse both as an individual with a value system and as a member of an occupational group with a code of ethics may or may not come under consideration by the nurse herself or by others involved in the situation. Such a conflict for the nurse can be brought out into the open and discussed and a working solution arrived at, or it can be dealt with by attempting to cover it over or pretending it does not exist. These latter types of so-called solutions, if engaged in enough, can lead to both formal and informal use of the social system to undermine the effects of the decision which was made either without any input from, or was not agreed to by, those in the position to implement the decision *vis à vis* the patient.

Some critics of the social structure found in hospitals have maintained that nurses are often required to meet various contradictory and mutually exclusive demands. This is evidenced by the fact that they are made accountable for the welfare of patients without always being permitted to assume any major responsibility in relation to them. To the extent that the structural arrangements in hospitals, the division of labor, and the process of decision-making still reflect this situation, it can be said that nurses are confronted with many of the ethical dilemmas confronting other health professionals, plus the additional dilemma of having to meet contradictory demands and attempting to find a working compromise in order to deal with the divided loyalties inherent in the situation. Legally, the nurse is accountable to the patient. Such a neatly packaged statement, true as it is, does not, however, take into account the culture and norms which develop in the hospital and which can act to inhibit the nurse in performing her duties in an ethical manner. The broad questions which arise in a situation of conflicting loyalties are as follows. By what moral principles does one reach a moral solution? Where does one draw the line and cease to be loyal, such as reporting an ethical dilemma, when one feels that a given situation is such that to be loyal is tantamount to being unethical? What potential risks does the nurse run in the above behavior, especially if she articulates the reasons for her moral position and one reason involves the unprofessional and/or unethical behavior of another? Will it make any difference to her possible future employment and/or career if the person whom she believes is unprofessional and/or unethical is in a superordinate position in the hierarchical structure? Can she depend on any support from the nursing administrators in the hospital? Are there any formal mechanisms at the ward level which can be used to deal with ethical conflicts between staff? In short, what price an ethical stance for the nurse employee in a hospital?

More has been heard about the rights of patients than about the rights of health professionals although a number of court cases have turned on the conflict between the two. For example, the situation where a patient refused treatment based on religious grounds may come into conflict with the health team's right and obligation to provide the best care possible. The New York Hospital Patient's Bill of Rights addresses this potential conflict by acknowledging the patient's right to refuse treatment but goes on to say that, "If the hospital staff feels that your decision to decline further treatment is seriously inconsistent with its ability to provide you with adequate care, you may be requested to make arrangements elsewhere."[3]

A consideration of the nurse's rights as a professional may provide us with some interesting insights and suggest some of the bases for the survey findings mentioned earlier which indicated widespread dissatis-

faction among nurses. A complex situation involving potential conflicts of rights stems from the nurse's combined status as a woman, as a nurse, and as an employee. One major criticism lodged against physicians in the medical ethics literature is that as a group they tend to be paternalistic. The behavior which paternalism encourages both in the doctor and the patient is viewed as a major inhibiting factor in the patient's right to information and to participate in the decision-making process regarding his treatment and care. In an historical account entitled, *Hospitals, Paternalism, and the Role of the Nurse*, Ashley extends the old adage, "Power corrupts and absolute power corrupts absolutely," to develop the other side of the coin: powerlessness corrupts, too, by undermining integrity and inhibiting human growth. This point has been supported by any number of social science studies researching minority groups, including women. Ashley's documentation that paternalism has resulted in serious and systematic injustice against women in the health sciences that has been both morally indefensible and socially damaging is overwhelming.[4] The question here then is, given the structural arrangements of the hospital and given the fact that most doctors and hospital administrators are male and most nurses female, what happens in daily transactions which either impede or enhance the nurse's right to provide adequate, if not excellent, nursing care? Is providing such nursing care viewed as a professional right, as well as an obligation; and if so, do nurses themselves, physicians, hospital administrators have similar or conflicting views which affect their attitudes and behaviors? If conflicting views exist, does this create ethical problems for the nurse and for other members of the so-called health team, including the patient? In thinking through the duties, obligations, and rights of nurses, the American Nurses' Association has developed a Code of Ethics.

The Nurse's Code of Ethics

In 1976 the American Nurses' Association updated its Code of Ethics. Previous Codes had been more prescriptive, identifying codes of both personal and professional behavior, describing appropriate relationships with physicians, and other health professionals, and identifying certain responsibilities of the nurse as a citizen, an employee, and a person. The updated Code, while remaining prescriptive, depends more on the nurse's accountability to the patient, and, in that sense, represents a change to an ethical code. This Code is based on belief about the nature of individuals, nursing, health, and society. Both recipients and providers of nursing services are viewed as individuals and groups who possess basic rights and reponsibilities, and whose values and circumstances command respect at all times. The Code provides guidance for conduct and relationships in carrying out nursing responsibilities consistent with the ethical obligations of the

profession and quality in nursing care. The specific elements of the Code* are:

1. The nurse provides services with respect for human dignity and the uniqueness of the client unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems.
2. The nurse safeguards the clients' right to privacy by judiciously protecting information of a confidential nature.
3. The nurse acts to safeguard the client and the public when health care and safety are affected by the incompetent, unethical, or illegal practice of any person.
4. The nurse assumes responsibility and accountability for individual nursing judgments and actions.
5. The nurse maintains competence in nursing.
6. The nurse exercises informed judgment and uses individuals as criteria in seeking consultation, accepting responsibilities, and delegating nursing activities to others.
7. The nurse participates in activities that contribute to the ongoing development of the profession's body of knowledge.
8. The nurse participates in the profession's efforts to implement and improve standards of nursing.
9. The nurse participates in the profession's efforts to establish and maintain conditions of employment conducive to high quality nursing care.
10. The nurse participates in the profession's effort to protect the public from misinformation and misrepresentation and to maintain the integrity of nursing.
11. The nurse collaborates with members of the health professions and other citizens in promoting community and national efforts to meet the health needs of the public.

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Any code for professionals represents the ethical ideal, and serious problems emerge when individuals believe that they cannot engage in an ethically-based practice. An earlier study, which supports the findings of the survey reported above, indicated that, among other things, nurses leave nursing because they cannot provide what they consider to be good nursing care in the hospital setting.[5]

Nurses and the Status of Women

Ample documentation now exists from numerous sources, including governmental material, to support the fact that our society discriminates against women. In every important arena of society — economic, social, educational, and legal — women have received, and continue to receive, less favorable treatment from society than do men. Of course,

this state of affairs is not new, nor is it limited to any one country at present but more nearly represents one of the cultural universals which anthropologists are always seeking. One study published in 1970 can give us an insight into the ingrained attitudes which both men and women have toward women.[6] This research demonstrates the extent to which contemporary mental health practitioners still hold a double standard of mental health with one for men and another for women. A sex-role stereotype questionnaire was completed by 79 clinicians (33 female and 46 male psychiatrists, psychologists, and social workers). Their instructions were to check off those traits that best describe healthy female, healthy male, and healthy adult with sex unspecified. The results were reported as follows. Among both men and women clinicians, there was high agreement as to the attributes characterizing healthy adult women, healthy adult men, and healthy adults, sex unspecified. Furthermore, clinicians have different concepts of mental health for men and women and these differences parallel the sex-role stereotypes prevalent in our society. Their concepts of healthy, mature women differed significantly from those for men and for adults. And finally, clinicians were likely to see that women differed from healthy men by being less independent, less aggressive, less competitive, less objective, less adventurous, less interested in math and science, more submissive, more easily influenced, more excitable in minor crises, more easily hurt, more emotional, and more conceited about their appearances. Essentially, what this study reveals is that these clinicians placed women in a double bind. If women behave like women, they are not behaving like mature, healthy adults; but also if women behave like healthy adults, they are not behaving like healthy women but more like men.

But the situation is more complex than that. Horner, in eight years of research, found that women still tend to view independence and intellectual achievement, competition and leadership as basically in conflict with femininity. The image of femininity has been internalized and has acquired the capacity to exert psychological pressures on behavior.[7] Despite the new freedom for women, negative attitudes toward successful women have increased. One study reported that among white females, 65% had negative attitudes in 1964 and by 1970, the rate had risen to more than 88%.[8]

The fact that nursing has remained a female occupation in which over 95% of its members are women must be taken into account in any discussion of ethics. Given their sex role socialization which may be reinforced by the nursing school experience, are nurses reluctant to assume responsibility for their own practice which, according to the Code, includes safeguarding the patient from incompetent, unethical, or illegal practice of any person? What happens to the nurse who takes the ethical aspects of clinical practice seriously? What kind of relation-

ship does she have with her male and female colleagues?

Internationally and nationally, nurses constitute the largest segment of the health care system. In some developing countries, often the nurse is the only health provider once one leaves the city. In a sabbatical experience in Sub-Saharan Africa, I attended a conference on medical manpower and the problem of insufficient numbers and maldistribution. Ministry of Health figures indicated that nurses were providing most of the people most of the health care. Once, however, the discussion got underway, it was almost as if nursing did not exist. Perhaps denial is functional and helps to maintain the power balance of the status quo.

The International Council of Nurses in Geneva updated its code of ethics in 1973. This document addresses the duties, obligations, and rights which nurses have as members of a profession with both national and international codes. This international code reads as follows:*

> The fundamental responsibility of the nurse is fourfold: to promote health, to prevent illness, to restore health and to alleviate suffering. The need for nursing is universal. Inherent in nursing is respect for life, dignity and the rights of man. It is unrestricted by considerations of nationality, race, creed, color, age, sex, politics, or social status. Nurses render health services to the individual, the family, and the community and coordinate their services with those of related groups.
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> The nurse's primary responsibility is to those people who require nursing care. The nurse, in providing care, respects the beliefs, values, and customs of the individual. The nurse holds in confidence personal information and uses judgment in sharing this information.
>
> The nurse carries personal responsibility for nursing practice and for maintaining competence by continual learning. The nurse maintains the highest standards of nursing care possible within the reality of a specific situation. The nurse uses judgment in relation to individual competence when accepting and delegating responsibilities. The nurse when acting in a professional capacity should at all times maintain standards of personal conduct that would reflect credit upon the profession.
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> The nurse shares with other citizens the responsibility for initiating and supporting action to meet the health and social needs of the public. The nurse sustains a cooperative relationship with co-workers in nursing and other fields. The nurse takes appropriate action to safeguard the individual when his care is endangered by a co-worker or any other person.
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> The nurse plays the major role in determining and implementing desirable standards of nursing practice and nursing education. The nurse is active in developing a core of professional knowledge. The nurse, acting through the professional organization, participates in establishing and maintaining equitable social and economic working conditions in nursing.

Some Major Types of Ethical Dilemmas for Nurses

Ethics and ethical dilemmas identified by nurses working in hospitals fall into two categories. The first category contains ethical issues which arise when the nurse violates her personal and/or professional

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code of ethics. For example, when the nurse makes a promise to a patient in good faith, and then does not keep it for some reason over which she has control, she has violated her ethical standards. The second category of ethical issues or dilemmas involves the working relationship with physicians. These ethical issues can take a number of different forms but three forms seem very common. One, for example, is the situation where the nurse finds herself having to cover up for the physician or to stretch the truth as in the situation where the physician says, "Tell my patient I have already left the building."[9] This may be viewed as an unimportant event and one not to be considered as an ethical issue; however, that overlooks the fact that the physician has asked the nurse to lie for him. This situation was chosen to illustrate the daily nitty-gritty ethical problems which arise. So often we think of only the cliffhangers of death and dying, abortion, or behavior control whereas it is in the daily routine that many ethical problems are embedded.

Some time ago a well-known medical ethicist delivered a lecture on truth-telling in medicine which deals with another form of ethical issues. At the end of the lecture someone raised a question as to health care providers other than doctors and their role in a situation where the doctor has decided not to tell the patient the truth. The response was that they ought not get involved. This response overlooks the fact that these others are involved in that they are on the scene, have certain information and are interacting with the patient and the patient's family. What happens if the patient openly asks the nurse a question which has to do with the information being withheld? She can, of course, always play dumb and refer it back to the doctor. However, some discussion among those who care for this patient regarding the decision, the rationale and the ethical implications, would help everyone.

Another situation arose in a famous hospital where an attending physician told the nurses not to tell the patient her temperature. In this situation the patient continued to ask and also knew that the nurses had this information. Because the nurses did not give her this information, the patient became very upset and thought all sorts of things about her condition. Finally, the director of nurses had to enter into the situation because it was getting so out of hand.

Another form of ethical dilemma occurs when the physician wishes to utilize the informal social system to achieve a goal, but such a use violates not only hospital policy but also places the nurse in an ethical dilemma. A true example illustrates this point. The physician in a well-known hospital was reluctant, for reasons having to do with his own values and professional code of ethics, to write an order not to resuscitate a patient; however, he asked the nurses caring for this patient to "walk slowly" when this patient needed resuscitation. Since hospital policy dictated that unless a specific order had been written

to the contrary, nurses were to proceed with resuscitation, and since the behavior being requested of the nurses by the physician violated their own professional code of ethics, this presented a serious ethical dilemma which could only be solved by having the parties involved in the situation discuss it openly. One of the remarks which came out of this discussion was from the physician who commented that nurses were always wanting more input into the clinical decision-making process and wanted to be accountable, but it seemed to him that this was not really the case. A comment from a young nursing student in another setting sums up this problem. After discussing what was to her a serious ethical dilemma she, with great concern, said, "The doctor comes in, writes the order, and leaves. I'm left to live with the implementation of that order hour by hour long after he has walked away. I think it would help me if we could talk about these issues and their ethical dimensions. More and more of the things I do seem to have such grave moral dimensions."

Nursing has a history of concern with the ethical dimensions of care. Because of nurses' position in the hierarchical system of the hospital and because of the fact that most nurses are women in an industry largely controlled by men, it just may be that for a nurse to be ethical is, in many instances, a risky business — the risk of losing a job, for example, as the lecturing medical ethicist said. The major theme of this paper is that since we have to work together to get the job done, let us take the time to ethically reason together in those situations of potential ethical dilemma so that everyone's ethical concerns are heard. It seems reasonable to assume that the patient can only benefit from this in both the short run and the long run.

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