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"Organization serves man and rules him, increases his scope and hems him in."

JOHN W. GARDNER[1]

Medicine involves a complex of relationships grounded in mutual trust and regulated by principles designed to protect the person of the patient. Despite the necessary and increasing intrusion of institutions, health teams, and machines, the personal dimension of medical care will always remain. Any change in the pattern of patient care or in the roles of physician and nurse must, therefore, carry important ethical implications.

Advances in contemporary science, technology, and social structure are creating profound alterations in patterns of medical care. Pressure is mounting for the adaptation of traditional responsibilities so that patients may receive the full benefits of new knowledge. Yet a critical assessment of traditional roles is needed if the new knowledge is to be exploited fully. A better definition of the potentialities of each of the rapidly proliferating health professions awaits whatever realignment of relationships are made in the central triad created by the patient, the nurse, and the physician.

Both medicine and nursing may fear that changes in established patterns of practice will eaten traditional values and ethi standards. But the threat will be ater if the professions do not c ientiously refurbish their functio before the requirements of cont porary knowledge.

ETHICAL CODES OF IE AMA AND ANA

Whenever long-cher ed convictions are challenged, ne reasonably firm bench mar must be established. The ethic principles and codes of the medic and nursing professions constitu an appropriate base for both cision and action. The doctor and e nurse, as well as the public, mu e-examine each current and propo change in the mode of providing dical care. To what extent will the hical codes of each profession mo fy and be modified by the current demands for revision?

The famed oath of Hippocrates has been the moral standard of western physicians for centuries. In 1847, the first year of its founding, the American Medical Association adopted its first code of medical ethics, patterned on that of Sir Thomas Percival, published in England in 1796.

The current revision of the AMA code was adopted in 1957. It reduces to ten admirably clear and brief paragraphs all the essential principles contained in the former codes. These paragraphs enjoin the physician to merit the confidence of his patient, continually improve his skill, practice scientific medicine, expose the unethical practitioner, uphold the honor of the profession, seek consultation, keep confidential information, charge reasonable fees for services actually rendered by him, and to avoid self-advertising and working in situations which would hamper freedom of judgment[2].

ETHICS AND ETIQUETTE

These codes, and the more ancient ones from which they derive, are an admixture of ethics and etiquette. Ethics deals with the rightness or wrongness of the physician's actions in the light of principles stemming from the nature of man as a person. It establishes normative guides which govern specific situations in such a way that the rights of the patient are always preserved. Professional etiquette, on the other hand, deals with matters arising out of the relations of physicians with each other and with the dignity of the calling.

The public has never found it difficult to understand the truly ethical principles which assure high standards of service and devotion. The proscriptions relating to the conduct of physicians with each other are less clear, and are sometimes erroneously interpreted as self-protective devices. The ban against advertising, the physician's work conditions, the manner of payment, fee-splitting, the courtesies of consultation, and the advancement of public health are not strictly matters of ethics. Their violation may impair the dignity or some of the goals of the profession, but they do not by nature involve usurpation of the human rights of the patient.

The revised code of the American Nurses Association contains the same intermingling of etiquette and ethics[3]. A fair number of its 17 statements are concerned primarily with the dignity and prerogatives of the profession rather than with the rights and duties flowing from the human nature of the patient. For example, being a good citizen, participating in nursing organizations, in legislation, and establishing terms of employment are exemplary ends in themselves but they are independent of the direct duties owed to the patient.

The truly ethical core of the codes of both professions derives from the

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[1]Gardner, J. W.: *Self Renewal*. New York, Harper Bros., 1964, p. 63.

[2]Principles of Medical Ethics, *JAMA* 164: 1484 (July 27) 1957.

[3]American Nurses Association: The Code for Professional Nurses, Amer J Nurs 60: 1287 (Sept.) 1960.

dignity and rights of the patient as a person. This is the criterion against which new arrangements must be measured. Any changes that derogate or compromise these principles are unjustified. The etiquette of the professions, on the other hand, could be altered materially if such changes allowed for better services to the patient.

The code of the AMA says little about interprofessional relationships except to warn against association with anyone who does not practice medicine based on scientific principles. The ANA code is somewhat more specific. It requires the nurses to assume responsibility for both "dependent and independent nursing functions," specifically forbids the delegation of nursing functions to unqualified persons, enjoins harmonious relations with physicians and other members of the health team, and states that the nurse must not participate in unethical procedures herself and should expose the unethical or incompetent conduct of others.

Even on close examination nothing can be found in either code that would countermand a realignment of roles. Rather, each code, devoted as it is to the good of the patient, implicitly imposes on each profession the duty to explore all possible avenues which might improve the technical and personal services rendered the patient.

What are some of the current tendencies in patient care, those in operation and those certain to be expanded as each health profession attempts to adapt to the responsibilities imposed by cur advances in biology and medici

THE TEAM APP CH

One adaptation in dical care necessitated by speci ation and the need to approach tient needs comprehensively is th designated by the much abused rd "team." Whatever we choose call it, the cooperative activity physicians, nurses, and other heal professionals is a patent necessit n optimum care today. It is in pensable if the preventive, rehab ative, and psychosocial dimensio of care are to be developed equ with the curative.

There are obvious nical problems and dangers any team arrangement. The ten ncy to diffuse responsibility is great. The competence of a gro instead of an individual must be ared. Tasks must be delegated d iminatingly to those most capabl of performing them. The difficu s of supervision are in direct portion to the size of the tea as is the threat to mutual tru Most important, the person-t person relationship is threatened.

Yet these difficulties ust be overcome, for the phys an can no longer care for his patient alone. To satisfy the ethical peratives of his profession, he today faces new duties. Few would challenge his role as captain of the health care team—as *primus inter pares*. As such, he has two primary tasks: to bring the highest degree of scientific competence to his task and to develop his skill as a coordinator. He must recognize his limitations, appreciate the skills of others, and be sensitive to his patients' need for services other than his own. On the other hand he is responsible for the competence of those to whom he delegates functions. He should consult his team associates. He must recognize that his role is sometimes primary and sometimes secondary, and that it varies with the phases of the patient's illness.

Nurses, social workers, and other personnel are professionals in their own right. The physician cannot justly control their clinical operations. As the ANA code points out, the nurse is responsible for both "dependent and independent functions." She is obligated to refuse to participate in actions she deems unethical, harmful to the patient, or against his interest. This is true of other members of the health team.

How do we reconcile this fact with the physician's role as coordinator? Obviously he must yield some of his individualism and accept the discipline of a conjoint effort in which he is the leader but without absolute prerogatives. But so, too, must the other health professionals, if the physician-coordinator role is to have real meaning.

DELEGATION OF RESPONSIBILITIES

The nurse, the aide, the technician, and others have recently assumed some of the technical tasks formerly belonging to the exclusive domain of the physician. One of the critical decisions for medicine and nursing is whether this assumption of technical tasks is the best direction in which to expand the role of the nurse. I prefer to consider such functions a limited part of her contribution. She should undertake them only when her training makes her the most competent person to perform them, or when they lead to better rapport with the patient.

Answers to specific ethical questions will depend upon the determinants in each actual situation. What is the physician's responsibility as coordinator as he delegates some of his technical functions? The tasks yielded up must not be regarded simply as prerogatives given to someone else. They are rather divisions of labor required for the good of the patient and made necessary by the complex structure of the hospital.

Any reassignment of tasks can be properly decided only by joint discussion; they must also be accepted as the moral responsibility of the person who assumes them. The ethical principles that protect the patient must remain operative.

The nurse or any other member of the health team who assumes technical duties must be held morally responsible for maintaining a high degree of competence in their performance. She must answer to the authority of the institution and to the coordinator for failures. Such failures can no longer be considered as exclusively those of the constituent professions. They are mutually shared and must be mutually considered and dealt with.

This implies the need for mutual criticism. There is an urgent need, deriving from the welfare of the

patient, to make these criticisms constructive rather than destructive if the physician and the nurse are to share responsibility more closely.

The same ethical questions which concerned us in our consideration of the team obtain in situations where technical functions are parceled out to others. The physician must be assured that the techniques are being competently carried out. His traditional concern for the welfare of his patient must still be primary even though he shares his care with many others.

There is currently great interest in recapturing and expanding the nurse's opportunities for close contact with the patient. This trend is vital, since the time the physician can spend with his patient is decreasing lamentably. He is asked to master more scientific information, coordinate the efforts of other health professionals, interpret vast amounts of technical data, and assume a larger role in institutional affairs. To assist him he will increasingly need someone who is in close contact with the patient, who understands the diagnostic and therapeutic plan, and who can make pertinent observations in the light of that plan and suggest ways of improving it. He will also need help in interpreting his plan to the patient and in detecting and managing the psychosocial aspects of the case. The nurse who can perform these functions will greatly enhance the patient-physician relationship and facilitate delivery of optimum medical care.

In any new system of patient care, a first requisite is to examine the whole process of c gation of responsibilities. The us procedure is to multiply tasks a techniques and then find peopl o perform them. A more fruit approach would be to look at th sks themselves in the light of e patient's real needs without re d for who does them now. If think in terms of functions to b iled rather than professions to be tisfied, the results might be better

RELATIONS WITH TH OSPITAL

In the past 50 yea physicians and nurses have becom creasingly a part of the bureaucra life of the hospital, with an atte nt loss of autonomy. The adva ges of this association to the pat ts are obvious, but there has be insufficient exploration of the eth principles which should guide p sician and nurse in their relati with the hospital and its admini ators. Each group avows an interes in the welfare of the patient, bu with divergent points of view.

A whole new set of r onsibilities and duties derive from his association. As the sociologists ave pointed out, the hospital is important part of the therapeutic milieu[4-6]. It seriously influences the patient's recovery as well as his acceptance and understanding of illness. The interprofessional relationship within the hospital is a significant factor in its therapeutic function. Each profession should resolve jurisdictional problems or problems of status which adversely affect patient care.

Hospital trustees and administrators, in turn, are charged by society with the legal responsibility for the extent and quality of care provided. They cannot entirely delegate this responsibility to the professional staff. Nor can they morally impede the work of the professional who wants to serve his patient to the fullest possible extent.

A more meaningful interchange between trustees, administration, and staff on the institutional philosophy of patient care, control of its quality, and adequacy to meet community needs is necessary. The hierarchy of values has to be weighed in any situation in which conflicting goals are encountered. The acceptance by medical staffs of institutional policies regarding patient care implies some adjustment of individual practices to those requirements.

The emotional charge of such an interchange can be held in check only by keeping the patient in the center of the picture. He is identifiable to all the participants — and independent of the status, prerogatives, and vested interests of any.

SUMMARY

Nothing in the ethical codes of the nursing professions in any way countermands actual or contemplated changes in the patterns of medical care. Each explicitly enjoins behavior which will serve the patient's welfare and preserve his dignity. Each also includes rules of etiquette which guide relationships between members of the profession and are designed to insure the dignity and integrity of that profession.

Rather than banning reassignment of roles in medical care, each code, by its insistence on the good of the patient, compels each profession to explore fully every possible avenue for improving service even when this means yielding professional prerogatives. Hopefully, the nurse-physician relationship can become an example to all who today are earnestly trying to apply contemporary knowledge to their patients in a personal and competent manner.

[4]Brown, E. L.: *Newer Dimensions in Patient Care, Part I,* New York, Russell Sage Foundation, 1961.

[5]Freeman, H. E., and others (eds.): *Handbook of Medical Sociology.* Englewood Cliffs, New Jersey, Prentice-Hall, 1963.

[6]Walstenholme, G. E. W. (ed). *Man and His Future,* Little, Brown and Company (in preparation).