
Ethical dilemmas in nursing

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Author's abstract

Nurses are increasingly realising that they can offer relevant information and participate in decision-making involving ethical issues. However, inter-professional communications are frequently inadequate, and do not permit exchange of opinions. The consequences are often frustrating and upsetting for nurses whose care is affected by others' policies. This paper explores these issues using some clinical examples.

Fundamental values of preserving life and alleviating suffering are shared by members of the medical and nursing professions. Codes of confidentiality, honesty and collegiality are also expected within these groups. However, the spirit of servitude and obedience questioned by Nightingale (1), but perpetuated by many nurses since, has created differences in the way dilemmas are faced and the context in which nurses and doctors consider their professional ethics. This article will explore some of these differences.

Traditionally nurses have taken orders from senior members of both professions and initiated only routine procedures. Their reasoning and intellectual skills were not fostered or valued. It therefore followed that decisions on medical as well as ethical issues were made by doctors (2). Increasingly now however, nurses are realising their therapeutic potential, and patients too require more involvement in their care and treatment decisions. Changes in nursing reflect a desire to become more responsible and contributory to the welfare of those who need care. Thus policies of unilateral decision-making are resented by those who are affected by the decisions, especially when they have good reasons to disagree and are faced with treatment consequences continually during their daily work (3).

Ethical issues in nursing must therefore be viewed within a context of an emerging professional conscience, within a multi-disciplinary team in which nurses have generally held a somewhat subordinate role, and in a situation where they have most contact (or could have) with patients and relatives. These factors should be explored to see where problems exist

and in order to attempt to promote inter-disciplinary harmony and support.

Recent developments in nursing practice reflect increased knowledge of effective care, changing needs of patients and an attempt by the profession to become complementary to doctors not poor substitutes or mere ancillaries. Expanding areas of need for care in Western society will probably not be met by health services, not only because of scarce resources but through changes in the nature of need. Increasingly the elderly and chronically disabled or ill, require assistance to manage daily living activities and their problems are practical, economic and social (4). It is often family and community factors which determine whether such people can maximise their capabilities and independence. While medical doctors may try to exploit these influences, their science and expertise concern the prevention and treatment of disease. Nurses, on the other hand, are attempting to care for people by understanding their personal strengths, motivations and other supportive resources (5). Exploitation and application of psychological and sociological knowledge as well as medical science is now needed to help provide relevant care. Giving guidance and comfort to enable patients and their families to cope with short or long-term problems is fundamental to nursing (6). This needs time, patience, knowledge, sensitivity and trust. Few nurses or doctors would disagree with this but the ethical implications of enabling this fully to develop should be considered.

Within this framework nurses are adopting more responsibility for identifying and planning to resolve or reduce illness and related problems. This requires freedom to gain information relevant to the patients' welfare, suggesting ways of dealing with problems and selecting priorities for care with the patient and others caring for him. Nursing work may also include performing other tasks which doctors prescribe, but it should also involve assessing and reporting patients' response to such treatments to physicians. A close professional-patient relationship with one or two nurses can be seen as essentially therapeutic in many situations. Acting as a friend, guide or advocate naturally follows when such contact is appreciated by the patient and planned by nursing staff.

Key words

Doctors; nurses; paternalism; decision-making.

Lowered status, inadequate preparation and (largely) female socialisation has produced many nurses who are passive and worried about the added responsibilities they are now expected to fulfill. In contrast, others more recently trained, are eager to contribute more of their intellectual, rational, as well as practical skills. Relationships with both patients and doctors will alter if nurses succeed in giving problem-oriented care as described, and they will inevitably become more involved in making judgements about what is best for patients.

One of the most important resources a nurse has to give patients is relevant information about their condition, their treatment and ways of coping with both. Contributions by nursing and other researchers have demonstrated that certain types of information are positively related to recovery and less discomfort after surgery and special tests (7). However, anxiety reduction is also a vital part of this process, and answering all the patient's questions honestly is probably one of the most effective sedations. Augmenting the explanation given by doctors at times of signing consent is sometimes beneficial, but the vexed questions on alternative forms of treatment or rates of risk, which vary regionally may present problems of dual loyalty. Maintaining the patient's trust in his doctor is essential and usually not difficult, but nurses are put in difficult situations when their beliefs or those of the patient himself are at variance with those of others in the medical and nursing team. Opportunities to discuss such differences should exist, but nurses need to gain more confidence in expressing their views. As one of their primary duties is to be honest to the patient and represent his interest before all others the advocacy role needs to be studied carefully, but to be effective it has to be accepted by the doctor. Some medical and philosophical authors support this completely; for instance Culver and Gert give many reasons why nurses can provide information and discuss treatment plans more effectively than others, and in conclusion say:

'... Making nurses in in-patient settings responsible for determining that the patient has adequate information for giving valid consent would help to institutionalise the nurse's role as patient advocate, and thus make it the nurse's professional duty to protect the patient from making decisions based upon inadequate information' (8).

This assertion rests on faith that nurses have adequate knowledge, empathy and communication skills and no one would disagree that these can always be improved. Doctors may well support one or two nurses whom they know and respect performing the advocacy role, but the idea of nurses in general acting as a go-between or a confidant discussing medical treatments may seem unacceptable to many. Emphasis on helping the patient to understand the purpose of certain prescriptions and of reflecting the patient's views

appropriately would be more constructive. Certainly literature on this subject reports communication and knowledge gaps and there is clear evidence that more involvement in treatment decisions is clearly advantageous (7). This aspect of the nurse's role should be promoted for the patients' benefit, yet it is perhaps professional respect between doctors and nurses which must grow, in order to permit frank discussions and questions when either disagree with their treatment plans, or when the nurse feels she should relay the patient's doubts or dissatisfaction to the doctor.

Controversy over whether nurses can or should question and disagree with doctors' decisions relates to the past structure of medicine and nursing, the pervading ethos of a strong medical profession and the current trends in our society where individuals are being encouraged to be more independent. Hierarchies in hospitals, in medicine and in nursing have required clear lines of authority, unquestioning respect for seniority and a health service for which the majority of patients feel grateful. Better education for carers allied to medicine and for those receiving care has encouraged questioning about and real interest in diseases, their treatments and advances in such fields. Intelligent students can no longer successfully be treated like maids or they leave 'the service'. Leadership in most professions comes from wisdom and without this followers or subordinates do not respect decisions. In other words paternalism is becoming redundant and authority has to be earned through knowledge and contribution. This has far-reaching consequences for ethical issues in health care.

Unilateral decisions on medical treatment (or lack of it) were justified in the past through a belief in benign paternalism: doctors knew more about medicine than others, they took the legal responsibility for their actions and most members of society were very grateful that this was so. In general this can now only be seen to be justified when responsible others cannot be informed or participate in such decisions. Philosophers' definitions of paternalism indicate clearly their own beliefs in its value. Dworkin (9) defines paternalism thus:

'... the interference with a person's liberty of action justified by reasons referring exclusively to the welfare, good, happiness, needs, interests or values of the person being coerced.'

Acting for someone's benefit, not necessarily against but without his or her consent seems to happen a great deal in health care, and particularly in hospital. Nursing paternalism (or maternalism) is very common, particularly with elderly people who are too weak or confused to refuse all the washing and exercise they are forced to receive (10). However, the recent changes in nursing philosophy which emphasise shared goals and maximal patient participation attempt to combat this (11). Medical practice is also recognising the benefits of negotiation and collaboration to

encourage 'compliance' (12). Indeed Weiss's modification or modernisation of the meaning of medical paternalism includes an accurate appraisal by the doctor of the patient's values, prior to decision-making (13).

Medical paternalism with respect to nurses, however, can now be seen as outmoded. Partnership not paternalism is probably more relevant to the future and both nurses and doctors need to work hard to realise the benefits for their patients. If nursing is to develop to meet the growing needs among the public for what it can give, others must accept this and aid its progress. Given that 'paternalism is interference with a person's freedom of action or freedom of information'. . . (14) it cannot be consistent with an expanding discipline whose members are creating and applying knowledge which is beneficial to those in need.

There is already a changing climate in health care and while doctors may object to the nursing process (15), yet few refute the worth of problem-oriented care. In order for nurses to develop their skills appropriately they need to face criticism and opposing views as does any public service. However, this should be rational and constructive and no longer rely on the power of a prestigious profession which thinks it knows best for patients as well as nurses.

Perhaps the greatest justification for collaborative decision-making on issues that affect patient care, is the subsequent involvement of staff with the effects of those decisions. In many situations it is unrealistic and indeed wrong for one person to decide and let others' work be determined by that decision in a way which contradicts their own professional code. At times so many people seem to be involved with one person's care: not only the patient and his or her relatives but several nurses, physiotherapists, social workers and doctors. The burden of ensuring they all feel consulted may at times seem very great. In reality, all too often decisions are taken by one or two members of staff and those left to administer care day after day are not involved with these judgements. In different places and in different situations the level of discussion and involvement varies, but nurses in particular should be offering more support to their medical colleagues by providing relevant information along with their considered opinions to improve the quality of these decisions and their expedition.

It may seem to some that this plea for more involvement is unnecessary in that where it is possible it already exists. Yet the consequences of paternalism from some medical colleagues and passivity and self-effacing behaviour from some nurses continues to provide ample cause for concern. This author's recent clinical experience provided three examples of decisions which were not negotiated with the nurses concerned and subsequently caused them great anguish. Brief accounts are provided to describe the consequences and perhaps demonstrate that both nurses and doctors need to change their behaviour if

ethical issues are to be given the time and attention they deserve, and if constructive and satisfying working relationships are to be promoted.

1) A 66-year-old man had suffered bilateral cerebral haemorrhages over the course of three months. After the first stroke he was hospitalised and became very depressed and expressed suicidal wishes. He was not therefore motivated to recover and regained little movement or power of speech. As he had no relatives and 'nothing to live for', staff felt troubled and powerless to help. His second haemorrhage left him totally paralysed, and semi-conscious, all basic care being required. This continued for two months, no positive signs of recovery being manifest. Medical staff therefore agreed with senior nurses on the ward to discontinue nourishing tube feeds and commence a three-hourly regime of restricted water. Two weeks later the patient contracted a chest infection and was only producing extremely small quantities of offensive urine. In this gravely dehydrated state despite all care he became generally malodorous and halitotic and few people entered his room.

One senior student had been assigned to the care of this patient in the day-time and was given the responsibility of planning nursing care and ensuring this was continued when she was not on duty. Her mounting distress that the patient was not being made comfortable in his last few days was only communicated to other nurses. Unfortunately she felt unable to talk to the physicians as the ward was extremely busy and they did not include visits to the patient during their rounds. After ten days the patient died and the nurse felt she had failed to maintain his dignity or speak up on his behalf.

This situation is not atypical. Nurses are all too reluctant to assert their concern or beliefs and medical priorities must primarily reflect active, curative treatment. The simple remedy of giving more fluids and of discussing this with the ward staff may have helped the patient and the nurse suffer less.

2) A fifty-year-old lady had been admitted for investigation of indigestion, vomiting and weight loss. After barium x-rays and gastroscopy a diagnosis of advanced gastric carcinoma was made. Surgeons recommended a palliative operation to reduce stenosis and felt it unwise to disclose the prognosis of six months to the patient. They did however discuss this with her husband who agreed his wife should not be told of the prognosis as she was 'very nervous' and had a phobia about cancer.

A junior staff nurse had been in charge on night duty during the week of the operation and had become very close to the patient who had required a lot of physical care and had asked not to be left alone when awake at nights. Three days later the staff nurse returned on day duty and was greeted warmly by the patient who was obviously much stronger and feeling more comfortable. After chatting for about ten minutes the patient disclosed her fears that the doctors were hiding something and that she did not want them to explain

things but that the nurse was the only person from whom she could accept the truth. Having explored the patient's fears of cancer previously, the nurse realised that she might induce severe distress if she mentioned this although the patient had confided that she would not be afraid of dying 'as long as it wasn't cancer'. Despite feeling that she was being asked to disclose the limited prognosis at this time and knowing that she would be available to support the patient for the rest of the day, the nurse decided to interrupt the conversation and ask permission from sister to disclose the prognosis but not the diagnosis. Sister did not agree to the nurse taking on the responsibility but agreed to talk to the relevant doctor. However, because of some delays by the time the patient was discharged she *still* had not been able to continue her talk with the nurse who was left feeling guilty and inadequate.

This second example illustrates once again the dilemma faced by nurses in that while they have opportunities to give psychological care they feel they have inadequate authority to continue this through to the full extent needed by patients. The rights or wrongs of disclosure may be an issue at times, but as Brewin (16) has said it is more often a case of providing skilled, open, fully informed communication than deciding on a policy and not altering that policy. It is important for all members of the team to recognise when particular members of staff have a special and confiding relationship with a patient in order to clarify issues and sometimes delegate authority for decision-making as events unfold.

3) A 40-year-old lady was found to have a malignant breast lump and her consultant recommended mastectomy. Her grief and dismay was evident to all as she wept for most of her first night in hospital and the following day. The ward sister tried to console her for over two hours on that morning. Surgery was scheduled for the next day and a nurse was assigned to her care that evening and for the next morning. By the evening the patient was discussing her diagnosis and treatment albeit tearfully. She asked about the possibility of other treatment and the nurse suggested that she discuss this with the doctor before signing her consent form. By the time the house surgeon arrived to explain the procedure it was eight o'clock that evening and he was rather shocked by the patient's bevy of questions and tried hard to explain why mastectomy was the best treatment. When he left the patient he expressed his anger at this unexpected turn of events to the nurse, whom he reprimanded for encouraging the patient to doubt the prescribed treatment.

The nurse in this case became very tearful and said she believed she had done what was best for the patient, who had clearly wanted more information. She also explained that she considered informed consent implied the right of the patient to ask questions about alternative treatments. This conversation did not allay the house surgeon's irritation and he then complained about the nurse to the ward sister, who duly reprimanded her the next day.

There are no doubt many suggestions for reducing the possibility of such situations being repeated and frequently better management has already prevented such conflict and distress. However, once nurses accept that they should feel accountable for providing a broad range of physical and psychological support for patients they will feel increasingly dissatisfied if their contributions to continuous and relevant care are not recognised. Lack of consultation or concern over the effect of ethical decisions on those involved in giving care not only destroys the satisfaction and esteem of members of staff, it can also reduce the quality of care intended (as illustrated in the vignettes above). Nursing and medical education should surely include more joint discussion sessions on ethical and treatment issues and be designed to provide more understanding of the principles and processes involved in providing the best and most complementary contributions to patient care.

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(continued on page 135.)

have better insight into these objective values than lay people. Both of these doctrines, and especially the latter, would seem not only questionable but untenable to many of us, thus weakening the force of Weiss's third argument.

We have now reached the heart of the argument against any form of paternalism, however 'modernised'. Medical paternalism is the doctrine, first, that 'doctor knows best', not only about technical and scientific matters, but about what is 'good for' the patient; and, secondly, that this justifies the physician in making the patient's decisions for him. Paternalism is to be rejected, both because the question of what is good for or bad for a particular individual is not an objective question, but one to be decided only by the individual himself or herself; and because no one else is therefore entitled to make my decisions on such questions for me. If I would sooner die rather than submit to the severe nausea induced by chemotherapy, then the physician, no matter how foolish he may think that decision, is morally bound to accept it. Medicine exists to care for individuals, and therefore presupposes the value of individuality and human autonomy. To advocate paternalism is in effect to say that patients exist for the sake of medicine, rather than that medicine exists for the sake of patients, since paternalism rests on the claim that the goods which medicine pursues are determined by the medical profession rather than by the patients who make use of their services. This is as true of Weiss's 'modernised'

paternalism as of the old-fashioned variety. The greater concern with ascertaining the patient's values and involving patients in their own treatment which seem to be the hallmarks of this modernised paternalism are, if this is genuine paternalism, merely a sham, since it is still the physician who makes the ultimate decisions about the patient's fate. On the other hand, if they are not a sham but a genuine concession to patient autonomy, then what Weiss is advocating is not the modernisation but the abandonment of medical paternalism.

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Editor's note

A response from Dr Weiss has been invited and is expected in due course.

(See also articles beginning pages 127 and 131.)

(continued from page 126)

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