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THE NURSE AS PATIENT ADVOCATE: IS THERE A CONFLICT OF INTEREST?*

I. INTRODUCTION

Nursing has been widely acknowledged in the last generation as an independent profession with its own body of knowledge and legal accountability.¹ Contemporary nurses² can be found managing the care of gravely ill infants in state-of-the-art neonatal intensive care units, functioning independently to ensure the health and safety of workers in industrial facilities, and providing primary emergency response to consumers in computerized poison control centers. The common element in these diverse settings is the nurse's primary responsibility to her patient. This responsibility, however, may involve the duty to support her patient in a decision contrary to the beliefs of the physician, institution or society as to what is "right."

The potential conflict between a nurse's ethical duty to her patient, and her legal duty to her employer and the physician, may expose the nurse to considerable professional risk." The strain on nurse-physician relationships is increased greatly in settings such as intensive care units, where nurses and physicians work in close contact under extremely stressful conditions which frequently involve ethical problems and dilemmas."⁵


² The word "nurse" as used by the author refers to a registered nurse who is licensed under state law to practice nursing.

³ Despite the fact that men have made important contributions to the profession of nursing, 97% of all registered nurses in the United States are women. Westfall, Legal Staffing Issues and the Nursing Shortage, 10 CAL. NURSING REV. 18-19 (1988). Therefore, for the sake of brevity female pronouns will be used to refer to nurses.


There is little to guide nurses in resolving these dilemmas. The law and standards of nursing practice are vague regarding patient advocacy. There is a paucity of state law regarding rights to ethical decision making for nurses. Nursing practice acts provide minimum guidelines, but often do not adequately define unprofessional behavior. Codes of ethics do not provide legal protection for the nurse who acts as a patient advocate and are often too abstract to apply with consistency.

The lack of usable guidelines results in confusion among nurses and attorneys over the types of behavior subject to sanction. Conduct that has been sanctioned includes the granting of a patient's request to discuss treatment alternatives, reporting unsafe conditions to the hospital's accrediting organization, and refusing to perform kidney dialysis for a terminal patient in order to avoid further complications. Sanctions commonly imposed on nurses include harassment, demotion or discharge, and suspension or revocation of a license to practice nursing.

This comment surveys cases in which nurses have been chastised for acting as patient advocates as mandated by professional codes of ethics, hospital policies and state law. The comment

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6. An intensive care service is a nursing unit in which there are specially trained nursing and supportive personnel and diagnostic, monitoring and therapeutic equipment necessary to provide specialized medical and nursing care to critically ill patients. CAL. ADMIN. CODE. tit. 22, § 70491 (1975).

6. Illinois Right of Conscience Act, ILL. ANN. STAT. ch. 111 1⁄2, para. 5302, § 2 (Smith-Hurd Supp. 1987), prohibits "all forms of discrimination, disqualification, coercion, disability or imposition of liability upon such persons or entities by reason of their refusing to act contrary to their conscience or conscientious convictions in refusing to obtain, receive, accept or deliver medical services and medical care." However, even Illinois, which offers the most comprehensive rights of this nature available to health care providers, has interpreted the Act to refer only to personal moral or religious convictions, as opposed to ethical objections, to the delivery of health care. See infra notes 96-97 and accompanying text.


13. The nurse's respect for the worth and dignity of the individual human being applies irrespective of the nature of the health problem. It is reflected in the care given the person who is disabled as well as the normal; the patient with the long-term illness as well as the one with the acute illness, or the recovering patient as well as the one who is terminally ill or dying.
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discusses the various defenses used by nurses against charges of wrongful behavior, as well as inconsistent judicial responses. Judicial
treatment of nursing advocacy is examined in the context of broad
historical trends in nursing as reflected in public opinion. Finally,
this comment suggests measures to eliminate some of the prevailing
confusion regarding rights and duties of patient advocacy so that
professional nurses can plan their conduct vis-a-vis patient advocacy.

II. BACKGROUND

A. Defining Patient Advocacy

The duty of patient advocacy arises from the rights of the pa-
tient as described in A Patients’ Bill of Rights promulgated by the
American Hospital Association, which provides that “activities must
be conducted with an overriding concern for the patient, and, above
all, the recognition of his dignity as a human being.”16 Respect for
the dignity of the patient specifically extends to the right to refuse
medical care.17 As of 1987, thirty-nine states had passed laws sup-
porting the patient’s right to die.18

The necessity for patient advocacy stems from the impact of ill-
ness on an individual’s autonomy and ability to make decisions,
which places the caretaker in a powerful position. “[T]he psycholog-
ic violence to which the person is subjected in the daily living expe-
rience as an institutionalized patient” creates a duty to assist patients

14. “The nurse must function as a patient advocate; that is, every decision by health providers must be evaluated in terms of its effect on the patient.” SANTA CLARA VALLEY MEDICAL CENTER NURSING SERVICES PHILOSOPHY A-6302-01 (March 4, 1985). See also 1983 ACCREDITATION MANUAL FOR HOSPITALS 118 (Joint Commission on Accreditation of Hospitals).


17. Id. at 1782.

in coping with this environment. This duty may be implemented in various ways depending on the particular needs of the individual patient.

The nurse’s obligation as an advocate has three basic components: (1) to inform patients of their rights in a particular situation, (2) to ensure that patients are given all the information necessary to make an informed decision, and (3) to support patients in decisions they make. The complexity of the medical environment requires a comprehensive model of advocacy. The nurse must determine which aspects of the model to utilize on a case-by-case basis.

The first aspect of the role of advocate is that of “counselor or lay therapist” serving to comfort, reassure and provide companionship. The caring and consolation which are an integral part of nursing have well recognized therapeutic effects. Another duty of the advocate is to help the patient reach an informed decision. This involves the exploration of therapeutic alternatives with the patient in regard to the impact on his or her particular lifestyle.

A third responsibility is that of “watchdog” of the patients’ rights. The nurse is responsible for safeguarding her patient from the incompetence of other health professionals. This may be a statutory duty as well as an ethical one. A fourth component of the advocacy model is that of spokesperson for patients who have difficulty speaking for themselves. Finally, the patient advocate must ensure both the quality and continuity of care delivered to

22. “The interpretation of the environment is important on general medical/surgical units. It is the sine qua non for the prevention of ICU psychosis or the onset of some of the other deleterious emotional after-effects of ICU placement.” Corless, Physicians and Nurses: Roles and Responsibilities in Caring for the Critically Ill Patient, 10 LAW, MED. & HEALTH CARE 72, 75 (1982); Sandroff, Is It Right? Protecting the M.D. or the Patient?, R.N. MAG. 28, 30 (Feb. 1981).
23. Abrams, supra note 21, at 261.
25. “The nurse acts to safeguard the client and the public when health care and safety are affected by incompetent, unethical, or illegal practice of any person.” A.N.A. CODE, supra note 13, at 1792.
the patient. This duty arises from the nurse’s role as continual observer of the patient’s condition in a fragmented health care system.

B. Historical Trends in Nursing

1. Traditional Images of the Nurse

A review of major historical trends in the development of nursing illustrates the problems inherent in the role of the nurse as patient advocate. There are three traditional images that are inextricably linked to the status of women, and which continue to inhibit public recognition of nursing as an independent professional discipline. These images are of the nurse as mother, religious disciple and unskilled servant.

   a. Nurse As Mother

   Since the skills of the nurse in her image as mother nurturing her young were considered to be instinctive, their possession did not elevate the status of the giver of such care. The concept of the “born nurse” has its origin in this image and was fostered by the medical profession for many years, partly in response to the perceived threat of encroachment by trained nurses on territory “belonging” to physicians. The importance of “womanly” qualities in a nurse was commonly used to buttress the argument that nurses needed little, if any, education. Since the American Medical Asso-

27. Corless, supra note 22, at 75.
28. L. CURTIN & M. FLAHERTY, supra note 5, at 68.
29. In a 1909 meeting organized by physicians to discuss the proper role of nurses, Dr. Henry Beates, president of the Pennsylvania State Board of Medical Examiners declared, “the instruction commonly prevalent in hospital training schools is not only absurdly too comprehensive, but dangerous. It is sufficient to almost entirely result in nurses assuming the right to usurp the functions of physicians.” J. ASHLEY, HOSPITALS, PATERNALISM AND THE ROLE OF THE NURSE 80 (1976) (quoting BEATES, THE STATUS OF NURSES: A SOCIOLOGIC PROBLEM 6 (1909)).

   This statement was made during a period in which the primary purpose of nursing training programs was to provide a free labor pool to hospitals. Theoretical learning was secondary. In 1896 Mary Adelaide Nutting, a nurse leader, deplored the fact that student nurses commonly worked 60 to 105 hours per week in exchange for their education. Id. at 35. “As late as 1933 the administrator of the Massachusetts General Hospital of Boston admitted that the monetary value of student nurse service in his hospital was the main reason for maintaining a school.” Id at 29.

30. “As a rule, women make the best nurses, or rather more of them have a natural aptitude for the work. . . . [T]he main supply of nurses must be from the ranks of women.” Ingles, The Physicians’ View of the Evolving Nursing Profession 1873-1913, 15 NURSING FORUM 123, 127 (1976) (quoting 15 BOSTON MED. & SURGICAL J. 610 (June 11, 1874)).
ciation pronounced itself the sole authority on the scope of nursing practice, this attitude had a profound effect on both public opinion and the education of nurses in this country.

One result has been inconsistency in nursing education. Nurses in all fifty states can qualify to take licensing examinations via any of three routes: a two year associate degree, a three year hospital diploma, or a four or five year baccalaureate degree. A baccalaureate degree has been proposed as the minimum requirement for licensure as a registered nurse by several state and national nursing organizations on the premise that a university degree is appropriate to provide the level of expertise necessary to function as a registered nurse and would bring order to a fragmented system of nursing education.

However, even baccalaureate nursing education seldom provides adequate instruction in ethics. Studies in the late 1970's reported that the majority of accredited universities offering nursing degrees "ignored, only slightly touched upon or haphazardly included" ethics in their curricula. Until the importance of the study of ethics is recognized, nurses will be forced to continue to make decisions without an adequate theoretical foundation. This results in difficulty in defending their ethical decisions.

b. Nurse As Religious Disciple

The second anachronistic image of the nurse, originating in the Middle Ages, is that of a religious disciple who cared for the sick as

31. See infra note 46 and accompanying text.
33. Id. at 390. "The proposal to require a baccalaureate degree for a license as a registered nurse has divided nursing as has no other issue." Greenlaw, Definition and Regulation of Nursing Practice: An Historical Survey, 13 LAW, MED. & HEALTH CARE 117, 120 (1985). The trend favoring the baccalaureate degree as the minimum requirement for state licensure was elevated to the level of a national debate in 1974 when the New York State Nurses' Association became the first to pass a resolution requiring a baccalaureate degree as the minimum educational preparation for a state license as a registered nurse. Subsequently, at least 47 state nursing organizations and several national nursing organizations, including the American Nurses' Association, passed similar resolutions. Bullough, supra note 32, at 389.

Since most nurses lack a university degree, there is strong and concerted opposition by nurses who feel their professional status and livelihood will be threatened by such a change. In addition, organizations such as the American Hospital Association will probably oppose any legislation to require a baccalaureate degree. Bullough, supra note 32, at 390. Furthermore, many nursing educators think the benefits of standardizing nursing education are outweighed by the potential disruption to the profession. Bullough, supra note 32, at 390. Therefore, legislation to support the baccalaureate requirement is unlikely to succeed in the near future.

34. ETHICAL ISSUES IN NURSING, supra note 19, at 29.
a means to salvation. Although viewed as an honorable vocation, the
goal of this behavior was antithetical to a view of nursing as a pro-
fession worthy of remuneration. Florence Nightingale perpetuated
this image by her concept of nursing as a monastic discipline involv-
ing "long hours of devoted work, and a measure of isolation from the
mainstream of society as even living arrangements for nurses con-
sisted of tightly controlled residences." In spite of Nightingale's ef-
forts to gain respectability for nursing, in the minds of many it re-
mained a calling, rather than a profession, suitable only for women
faced with the prospect of spinsterhood.

c. Nurse As Servant

The third historical image, the nurse as servant, evolved be-
tween the sixteenth and nineteenth centuries as nursing entered its
"Dark Ages." It was during this period that women, unmotivated by
the religious fervor of their predecessors, entered nursing primarily
as a last resort. Many were indigent illiterates or criminals who
exploited and abused patients. Since they were generally regarded as
unskilled labor, nursing was at its nadir as a profession.

2. Development of Divided Loyalties

Nursing entered its modern phase during the Victorian era
when the prevailing philosophy of female virtue stressed obedience to
the male. The emphasis on blind loyalty to the doctor extended
even to lying to the patient if so ordered. The persistence of this
attitude is demonstrated by the 1950 American Nurses' Association
Code for Nurses, which stated that the nurse's obligation was to
carry out the doctor's orders and protect his reputation.

Although the American Nurses' Association has since changed

35. L. Curtin & M. Flaherty, supra note 5, at 68.
36. L. Curtin & M. Flaherty, supra note 5, at 68.
37. "A fundamental error obtains in attempting to designate the occupation of a nurse
as a profession. . . . The work of a nurse is an honorable 'calling' or vocation, and nothing
further." Ingles, The Physicians' View of the Evolving Nursing Profession 1873-1913, 15
Nursing Forum 123, 147 (1976) (quoting Thompson, The Over-Trained Nurse, 83 N.Y.
Med. J. 851 (April 28, 1906)); B. Ehrenreich & D. English, Witches, Midwives and
38. L. Curtin & M. Flaherty, supra note 5, at 69.
40. J. Ashley, supra note 29, at 75-76.
41. L. Curtin & M. Flaherty, supra note 5, at 80.
42. Ethical Issues in Nursing, supra note 19, at 72.
its primary directive to loyalty to the patient,43 attitudes of obedience continue to pervade the profession. As recently as the late 1970's, a study of the moral reasoning of nurses found that many of them still operated at a traditional level that stressed "obedience to authority and the need for maintaining harmonious relationships with institutions and authority figures 'even when patients' rights were being violated.'"44

The structure of early formal nursing education also contributed to unquestioning institutional loyalty. Most nursing schools were hospital based. In an era of limited geographical mobility, this resulted in nurses identifying with their training institutions rather than with other nurses as members of a profession.45

In addition, hospital schools were typically controlled by physicians who methodically quashed the development of nurses' independent judgment. In 1906, the Journal of the American Medical Association stated that "[e]very attempt at initiative on the part of nurses . . . should be reproved by the physician and by the hospital administration. . . . The professional instruction of nurses should be entrusted exclusively to the physician, who only can judge what is necessary for them to know."46

Although doctors no longer control nursing education, most nurses do not function as independent practitioners. They implement the orders of physicians and function as employees within the bureaucratic structure of an institution,47 yet they are taught that their primary responsibility is to the patient. The adoption of these divergent loyalties can lead to fundamental conflicts. The nurse who is ordered by a physician to perform an act that she believes is unethical, illegal or detrimental to the patient faces a difficult personal and professional dilemma.48

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43. A.N.A. Code, supra note 13, at 1790.
44. ETHICAL ISSUES IN NURSING, supra note 19, at 72 (citing C.P. Murphy, THE MORAL SITUATION IN NURSING 315 (no date given)).
45. Comment, supra note 1, at 841.
46. J. ASHLEY, supra note 29, at 77-78 (quoting Nurses Schools and Illegal Practice of Medicine, 47 AM. MED. ASS'N 1835 (1906)).
47. In 1980 approximately 78% of all nurses practiced in institutions as employees. Smith & Davis, Ethical Dilemmas: Conflicts Among Rights, Duties, and Obligations, 1980 AM. J. OF NURSING 1463.
48. For instance, in Barber v. Superior Court, a case in which two doctors were initially indicted for murder, nurses were forbidden to provide intravenous fluids as a comfort measure to a comatose patient. 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (1983). The nursing supervisor who protested this allegedly inhumane treatment was unable to resolve the resulting conflicts within the hospital system and resigned in order to file a complaint with the county health department. "Even today, I still don't know what a nurse should do when following a
C. Judicial Treatment of Patient Advocacy

As a result of the public image of nurses, "historically, there has been considerable confusion in the courts regarding the nature of a nurse's liability." \(^4\) Until recently, judges have been reluctant to hold nurses to a standard of care comparable to that of other professionals. The standard of care of the ordinary citizen was considered appropriate to evaluate any alleged negligence of a nurse. \(^5\) Nurses could not be found guilty of malpractice, which is defined as "professional misconduct." \(^6\) To the extent that nurses are not regarded as professionals, their ethical decisions have not been accorded legal merit by judges. The result of this attitude is that the sanctions applied to nurses who make ethical decisions have been largely upheld by the courts.

The cases discussed below uniformly involve institutional reprisals for good faith attempts by health professionals, primarily nurses, to act in the best interests of their patients. The various plaintiffs sought relief via a number of legal theories with notable lack of success.

1. Public Policy Exceptions to the Employment-at-Will Doctrine in Wrongful Termination Cases

The most common legal claim made by the health professionals sanctioned in these cases was in tort for wrongful discharge. Since

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51. BLACK’S LAW DICTIONARY 864 (5th ed. 1979) (emphasis added). This meant that nurses were subject to different procedural rules as well, such as applicable statutes of limitations and the need for expert witnesses. “When an action against a nurse is based on negligence, as distinguished from malpractice, expert testimony is generally held unnecessary in order to establish the standard for judging the defendant.” Morris, supra note 1, at 111.

The view of nursing as a profession dependent on physicians has also led to the use of doctors as expert witnesses in jurisdictions where nurses are held to a professional standard of care. However, a doctor’s erroneous opinion regarding appropriate professional conduct for nurses may lead to inequitable decisions by courts which do not understand that the nurse’s role is not encompassed by the physician’s. “[N]ot only do physicians no longer have the special knowledge required to testify in all cases of nursing malpractice, but their use as experts may create problems that could be avoided by using nurses as experts in most nursing malpractice cases.” Note, supra note 50, at 590 (citing Comment, The Use of Nurses As Expert Witnesses, 19 HOUS. L. REV. 555, 571 n.113 (1982)).
most of the health professionals were not covered by employment contracts, their claims entailed creative attempts to carve public policy exceptions from the traditional employment-at-will doctrine, which allows termination of employment by either party without cause. The plaintiffs sought to convince the courts that their conduct was supported by important public concerns, such as patient welfare and safety. They argued that public policy warranted preventing their employers from discharging them in retaliation for professional decisions made in the best interests of their patients. Judicial acceptance of a public policy defense against wrongful discharge has depended primarily upon whether the source of the public policy supporting the plaintiff's behavior is statutory or non-statutory.

a. Nonstatutory Sources of Public Policy

Courts have been unwilling to accord public policy status to nonstatutory sources of policy such as professional oaths and codes of ethics. In Pierce v. Ortho Pharmaceutical Corp., Dr. Pierce, a research physician, was allegedly forced to resign in response to her refusal to work on the development of a drug she felt was hazardous to the public. She argued that continuing work on the drug would violate her vow to do no harm as a medical doctor under the Hippocratic oath, and urged the New Jersey Supreme Court to recognize this proscription as public policy, thereby giving rise to a cause of action for wrongful discharge.

While acknowledging the trend toward more liberal public policy exceptions to the employment-at-will doctrine, the court ruled that the general language of the Hippocratic oath fell short of the standard required for judicial elevation to the level of public policy. The court stated that an employee has a cause of action for wrongful discharge only when the discharge is contrary to a "clear mandate" of public policy. However, the court tempered the pronouncement

52. "Generally a contract of employment for an indefinite term is a 'contract at will' and may be terminated by either party, whereas a contract for a definite term may not be terminated before the end of the term, except for cause or by mutual agreement . . . ." Joshua v. McBride, 19 Ark. App. 31, 34, 716 S.W.2d 215, 217 (1986) (citing Griffin v. Erickson, 277 Ark. 433, 436-37, 642 S.W.2d 308 (1982)).
54. 84 N.J. 58, 417 A.2d 505 (1980).
55. Id. at 74, 417 A.2d at 513.
56. Id. at 76, 417 A.2d at 514.
57. Id. at 72, 417 A.2d at 512.
that a clear mandate emanates only from sources such as the legislature and administrative rules with the statement that "[i]n certain instances, a professional code of ethics may contain an expression of public policy." The burden of proof was placed on the employee to identify a specific expression of public policy that the court would scrutinize on a case-by-case basis.

The court criticized Dr. Pierce for failing to use a professional code of ethics to buttress her ethical objections to the drug experiments. It recognized that professional employees "owe a special duty to abide not only by federal and state law, but also by the recognized codes of ethics of their professions." The broad reach of this statement was limited, however, by the proviso that while this duty may oblige them to decline to perform acts required by their employers, it does not permit them to prevent their employers from pursuing their business.

The court admonished professional employees to distinguish business decisions that offend their personal morals from violations of their professional code of ethics. The court stated that if the objection is derived from personal moral beliefs, the employee must realize that there is room for reasonable minds to differ. However, the court failed to identify a method by which this sometimes difficult distinction can be applied.

In Warthen v. Toms River Community Memorial Hospital, a New Jersey appellate court declined to follow the Pierce court's recognition of codes of ethics as potential sources of public policy. Plaintiff Corrine Warthen, a nurse specialist in kidney dialysis, was assigned to dialyze a terminally ill double amputee patient in renal failure. On two occasions she had to terminate the procedure because the patient suffered cardiac arrest and severe internal hemorrhaging. Warthen notified her supervisor in a timely manner of her "moral, medical and philosophical objections" to performing a procedure that further complicated a terminal patient's condition. When Warthen refused to perform dialysis as ordered, she was fired.

Warthen attempted to use the American Nurses' Association Code for Nurses to justify her behavior. The Code requires that the nurse demonstrate respect for human dignity. It also provides that a

58. Id.
59. Id. at 71-72, 417 A.2d at 512.
60. Id. at 72, 417 A.2d at 512.
61. Id. at 75, 417 A.2d at 514.
63. Id. at 21, 488 A.2d at 230.
nurse who is "personally opposed to the delivery of care in a particular case because of the nature of the health problem or the procedures to be used . . . is justified in refusing to participate." The Code stipulates that the nurse must make her refusal known in time for other arrangements to be made.

The court acknowledged Warthen's good faith effort to comply with her professional code of ethics, but held that the Code did not provide the clear mandate required by Pierce because the passage on which she relied defined "a standard of conduct beneficial only to the individual nurse and not to the public at large."

The court's decision was also based on a conflicting public policy recently recognized by the New Jersey Supreme Court: patients' right to expect that medical treatment will not be terminated against their will. The court held that "[t]his basic policy mandate clearly outweighs any policy favoring the right of a nurse to refuse to participate in treatments which he or she personally believes threatens human dignity." The court also feared that it would be virtually impossible to administer a hospital if nurses were allowed the freedom to make decisions not to treat patients based on their personal beliefs.

A central issue in the case was whether the decision regarding public policy was a matter of fact that should have been resolved by a jury or whether the trial court was correct in granting summary judgment for the defendant. The court based its decision on Pierce, in which the New Jersey Supreme Court stated that the determination of whether a clear mandate of public policy exists must be made on a case-by-case basis as a matter of law. The opinion analogized the identification of a mandate of public policy to the court's duty to interpret statutes or define duty in negligence cases.

The court effectively closed the door on the use of professional codes of ethics as public policy exceptions to the employment-at-will doctrine when it stated, "The source of public policy is the statutes enacted by the legislature and in the decisions of the courts; there we

64. A.N.A. Code, supra note 13, at 1790.
65. A.N.A. Code, supra note 13, at 1790.
67. See In re Conroy, 98 N.J. 321, 486 A.2d 1209 (1985). Although the patient in Warthen was comatose and his wishes in this regard unknown, the family wanted the dialysis treatments to continue. Warthen, 199 N.J. Super. at 27, 488 A.2d at 233.
68. Id. at 27, 488 A.2d at 234.
69. Id. at 27-28, 488 A.2d at 234.
70. Id. at 23-25, 488 A.2d at 231-32.
find what acts are considered harmful to the public and therefore unlawful.  

b. Statutory Sources of Public Policy

1) Nurse Practice Acts

“Courts have been more willing to limit the at-will rule when the discharge contravenes an established public policy, particularly a legislatively declared policy.” However, attempts by nurses to derive public policy exceptions from existing legislative sources have demonstrated their inadequacy. In Lampe v. Presbyterian Medical Center, the plaintiff, head nurse of an intensive care unit, brought suit for retaliatory discharge on the grounds that her termination violated a mandate of the Colorado Nurse Practice Act.

Lampe's responsibilities included implementing staffing for the intensive care unit. Although Lampe was ordered to reduce overtime expenditures, she felt she was unable to decrease the amount of overtime worked without jeopardizing her patients and was fired for being “unwilling to fulfill the requirements of her job description.”

Lampe relied on the legislative declaration of policy contained in the Nurse Practice Act requiring a nurse to act in a manner consistent with the health and safety of her patients. She contended that had she obeyed the instructions of her employer to reduce overtime, she would have violated the statute under which she was licensed.

The court refused to allow the broad statement of policy contained in the statute to impute a legislative intent to “modify the contractual relationships between hospitals and their employees in such situations.” Thus, Lampe was denied a claim for relief due to lack of prescriptive specificity in the statute governing her professional behavior.

In contrast, Tuma v. Board of Nursing demonstrated the prescriptive inadequacy of a nurse practice act. Plaintiff Tuma, an instructor of clinical nursing, requested to be assigned to administer chemotherapy to a patient with leukemia because of a special interest

71. Id. at 25, 488 A.2d at 232 (citing Schaffer v. Federal Trust Co., 132 N.J. Eq. 235, 240-41, 28 A.2d 75, 79 (1942)).
72. Note, supra note 53, at 850.
74. Id. at 466, 590 P.2d at 514.
75. Id. at 467, 590 P.2d at 515.
76. Id. at 468, 590 P.2d at 515-16.
77. 100 Idaho 74, 593 P.2d 711 (1979).
in the needs of dying patients. The patient "pleaded with Tuma to return that evening to discuss an alternative treatment" to the chemotherapy.\textsuperscript{78} Tuma discussed the possibility of laetrile and dietary therapy with the patient, but the chemotherapy was continued and the patient died two weeks later after experiencing serious adverse side effects from the chemotherapy.\textsuperscript{79}

Although there were no allegations that Tuma had caused harm to the patient, complaints were made to the Board of Nursing by "[h]ospital personnel that Tuma had interfered with the physician-patient relationship."\textsuperscript{80} A hearing officer concluded that Tuma's discussion of treatment alternatives with her patient constituted unprofessional conduct in violation of the Idaho Nurse Practice Act.\textsuperscript{81} Despite the fact that the Nurse Practice Act stipulated that the policies of the Board of Nursing conform to the policies and practices of the American Nurses' Association, the hearing officer would not allow Tuma to testify regarding her knowledge of the professional ethics provisions contained in the American Nurses' Association Code for Nurses.\textsuperscript{82} The Board of Nursing affirmed the hearing officer's decision and suspended Tuma's license for six months.\textsuperscript{83}

On appeal, the Idaho Supreme Court found nothing in the language of the Nurse Practice Act to put Tuma on notice that her license would be suspended if she engaged in the contemplated behavior.\textsuperscript{84} The court decried Tuma's deprivation of an important property right in the absence of guidelines established by the Board of Nursing, especially in view of the fact that the hearing officer did not possess the expertise to determine whether Tuma's conduct was unprofessional.\textsuperscript{85}

Moreover, the Minimum Standards, Rules and Regulations promulgated by the Idaho Board of Nursing require nurses to "[p]romote, and participate in, patient education based on the individual's health needs . . . ."\textsuperscript{86} The court pointed out that this mandate actually supported Tuma's decision to discuss treatment alternatives with her patient. The court therefore held that the Board of Nursing violated Tuma's due process rights by authorizing the sus-

\textsuperscript{78} Id. at 75, 593 P.2d at 712.
\textsuperscript{79} Id. at 76, 593 P.2d at 713.
\textsuperscript{80} Id.
\textsuperscript{81} Id. at 76-77, 593 P.2d at 713-14.
\textsuperscript{82} Id. at 80 n.2, 593 P.2d at 715 n.2.
\textsuperscript{83} Id. at 79, 593 P.2d at 714.
\textsuperscript{84} Id. at 82, 593 P.2d at 717.
\textsuperscript{85} Id. at 85, 593 P.2d at 720.
\textsuperscript{86} Id. at 83 n.3, 593 P.2d at 718 n.3.
pension of her license on the grounds of unprofessional conduct without a specific statutory definition of such conduct. 87

2. Other Statutory Sources of Public Policy

Attempts to use statutes other than those pertaining directly to nursing to support a public policy argument have also met with little success. In *Maus v. National Living Centers*, 88 plaintiff Maus, a nursing assistant, was a long-term dedicated worker in a nursing home. After the home was purchased by defendants, Maus felt that conditions deteriorated to the detriment of the patients. In response to her complaints to superiors that the patients were being neglected, Maus was terminated from her job. Maus brought a wrongful discharge action against her employer, citing a Texas statute that makes the failure of nursing home owners or employees to report neglect or abuse of patients a criminal misdemeanor. 89 She argued that tort law should be extended to allow the reporting statute to create a public policy exception to the traditional employment-at-will rule.

Recognizing that it stood “at the cross-roads of two important public policies,” the court nevertheless decided that the time had not yet come to create a new right of recovery for wrongful discharge, and deferred the decision to the state supreme court or legislature. 90 Thus, health care providers in Maus’ position are left with the dilemma of whether to commit a criminal violation in order to keep their means of livelihood.

In another recent case, *Free v. Holy Cross Hospital*, 91 an Illinois nurse utilized a unique statute 92 in an unsuccessful attempt to support her argument for a public policy exception to the employment-at-will doctrine. Nurse Free was employed as a hospital shift supervisor. She was ordered to transfer a patient who had been ar-

87. *Id.* at 82-83, 593 P.2d at 717.
88. 633 S.W.2d 674 (Tex. Ct. App. 1982).
89. *Id.* at 675.
90. *Id.* at 676.
92. At least 44 states have adopted conscience clauses to protect health care providers from discrimination for refusal to participate in abortions. Durham, Wood & Condie, *Accommodation of Conscientious Objection to Abortion: A Case Study of the Nursing Profession*, 1982 B.Y.U. L. REV. 253, 308-09. Illinois, however, is the only state which has extended this protection to any act “contrary to . . . conscientious convictions in refusing to obtain, receive, accept or deliver medical services and medical care.” *ILL. ANN. STAT.* ch. 111 1/2, para. 5302 (Smith Hurd Supp. 1987).
rested for possession of a handgun to another facility. When Free could not locate a receiving hospital to accept the patient, she was instructed to proceed with the transfer “even if removal required forcibly putting the patient in a wheelchair and leaving her in the park.” Her attempt to intervene on behalf of the bedridden patient resulted in her immediate discharge by the hospital’s vice president.

Free argued that she was wrongfully discharged in contravention of the Illinois Right of Conscience Act, which prohibits discrimination against health care personnel who act in accordance with the dictates of their conscience regarding delivery of health care. The court interpreted the Act to apply to moral convictions arising from sincerely held religious beliefs, as opposed to ethical concerns relating to Free’s duty as a registered nurse. Since Free did not allege that the acts she was ordered to perform violated traditional religious beliefs, the court refused to use the Right of Conscience Act to create a public policy exception to her employer’s right to discharge her.

Although the court stated that the ethical concerns expressed fell into the province of the Illinois Nursing Act, it did not address the alternative of using it as a legislative source of public policy to protect Free’s actions.

Sides v. Duke University, a North Carolina case, is unusual in that a nurse was successful in litigating a wrongful discharge claim based on a statutory public policy exception to the employment-at-will rule. Sides was ordered by a physician to administer a drug she believed would be harmful to her patient. When Sides refused to administer the medication the physician did so himself, causing the patient to suffer a cardiac arrest and subsequent brain damage.

During pretrial discovery in the ensuing lawsuit, Sides was warned by several hospital physicians and attorneys not to tell all she had seen of the incident and threatened that she “would be in trouble” if she did so. Despite these threats Sides testified truthfully and the jury returned a verdict in favor of the patient’s estate in the amount of $1,750,000. Shortly thereafter Sides was terminated.
on the grounds of "an abusive attitude" and poor job performance, although the hospital refused to disclose specific instances of poor performance.\textsuperscript{102}

The court recognized the importance of public policy limitations on an employer's right to discharge an employee because "in a civilized state where reciprocal legal rights and duties abound the words 'at will' can never mean 'without limit or qualification.'"\textsuperscript{103} Therefore, the court departed from established common law in North Carolina by holding that no employer has the right to discharge an employee without civil liability for refusing to testify untruthfully in a court case.

Due to the existence of criminal penalties for perjury, the court stated that to hold otherwise would sanction lawlessness at the expense of innocent victims.\textsuperscript{104} The court echoed the dictum of the New Jersey Court of Appeals in \textit{Warthen v. Toms River Community Memorial Hospital}\textsuperscript{105} in its insistence on a legislative source of public policy to create a balance between employers' right to discharge and employees' need for protection from the harshness of the at-will rule.\textsuperscript{108}

Despite the trend toward recognition of the need for public policy limitations on an employer's absolute right to discharge an employee,\textsuperscript{107} the at-will-employee nurse who attempts to challenge termination of her employment on the basis of public policy, statutory or otherwise, clearly faces an uncertain fate.

\textbf{2. Constitutional and Federal Statutory Protection Against Wrongful Discharge}

Nurses able to take advantage of federal laws or constitutional protection have fared better in suits involving retaliation for patient advocacy. \textit{Jones v. Memorial Hospital System}\textsuperscript{108} involved an intensive care nurse who was discharged for writing a magazine article concerning conflicts between the duty of hospital personnel to prolong life and the right of patients to die with dignity. Jones used a

\begin{itemize}
\item \textsuperscript{102} \textit{Id.} at 334, 328 S.E.2d at 821-22.
\item \textsuperscript{103} \textit{Id.} at 342, 328 S.E.2d at 826.
\item \textsuperscript{104} \textit{Id.}
\item \textsuperscript{105} 199 N.J. Super. 18, 25, 488 A.2d 229, 232 (1985). \textit{See supra} note 71 and accompanying text.
\item \textsuperscript{106} Note, \textit{supra} note 53, at 850-51.
\item \textsuperscript{107} The \textit{Sides} court noted at length that the doctrine of employment-at-will has come under increasing criticism as being "unfair and no longer suited to the evolving economic relations between employer and employee." 74 N.C. App. at 339, 328 S.E.2d at 824.
\item \textsuperscript{108} 677 S.W.2d 221 (Tex. Ct. App. 1984).
\end{itemize}
blend of fictitious and actual cases to express her point of view as a nurse caught between doctors' orders and patients' wishes. She argued that her discharge violated her rights under the freedom of speech clause of the Texas Constitution.\textsuperscript{106}

The appellate court reversed the lower court's summary judgment, stating that the ethical and social issues concerning a patient's right to die were a matter of public concern and therefore the article was entitled to constitutional protection. The court pointed out that Jones' "article contributed to the public forum a viewpoint that might not otherwise be considered."\textsuperscript{110}

The court was careful to distinguish Jones from Maus v. National Living Centers,\textsuperscript{111} which also involved the discharge of a health care provider in retaliation for patient advocacy. The court affirmed the Maus court's refusal to recognize a public policy exception to the at-will employment rule. Therefore, the court concluded, the hospital was entitled to discharge Jones on any grounds that were not constitutionally protected.\textsuperscript{112}

Better protection may exist for nurses employed by public hospitals. In Rookard v. Health and Hospitals Corp.,\textsuperscript{118} Margaret Rookard was employed as Director of Nurses at Harlem Hospital, where she supervised a staff of approximately 1000 people. When Rookard took steps to correct numerous wasteful and illegal practices she was harassed with anonymous, threatening phone calls and letters.\textsuperscript{114}

Rookard reported these matters to the Inspector General of the municipal Health and Hospitals Corporation. One month later she was demoted. Several months after her demotion, she was offered the option of termination or an entry-level nursing position. Rookard challenged the hospital's actions on the grounds that they violated her first amendment right of free speech regarding matters that were of public concern.

\textsuperscript{109} Id. at 224.
\textsuperscript{110} Id.
\textsuperscript{111} 710 F.2d 41 (2d Cir. 1983).
\textsuperscript{112} 710 F.2d 41 (2d Cir. 1983).
On appeal, the Second Circuit upheld Rookard’s affirmative duty to act on matters which were her proper concern. The court stated that Rookard’s treatment by Health and Hospitals Corporation evidenced an official policy that “blowing the whistle would not be tolerated and would be met with swift retribution.”116 The court held that in view of Rookard’s long and distinguished career as a nursing administrator, the discharge could only be explained as retaliatory and reversed the lower court’s decision.116

In *Misericordia Hospital Medical Center v. NLRB*, the National Labor Relations Board ordered a hospital to reinstate a head nurse who had been discharged for reporting inadequate staffing and unsanitary conditions to the Joint Commission on Accreditation of Hospitals.117 The report was presented by plaintiff at a public information interview, in which interested parties were invited to present relevant information on whether standards were being met. Nine days later, after fifteen years of satisfactory service, Nurse Cafaro was fired because “she did not fit in with the . . . goals of Misericordia Hospital.”118

On appeal, the Second Circuit noted that in the health care field, issues relating to patient welfare and employee working conditions are often “inextricably intertwined.”119 Therefore, Cafaro’s conduct came within the ambit of the National Labor Relations Act, which protects employees’ right to act collectively for the purpose of mutual aid or protection.120 Significantly, the court approved the NLRB’s finding that Cafaro was bound by the American Nurses’ Association Code for Nurses to improve standards of nursing care and that therefore, “Cafaro’s contribution to the Report was ‘a step toward meeting’ her professional obligations.”121

In *Wrighten v. Metropolitan Hospitals*, a black registered nurse successfully invoked Title VII of the Civil Rights Act of 1964

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115. *Id.* at 47.
116. *Id.* at 46-47.
117. 623 F.2d 808 (2d Cir. 1980).
118. *Id.* at 811.
119. *Id.* at 813.
120. *Id.* The court also affirmed the NLRB’s finding that, as head nurse, Cafaro was not a statutory supervisor. Her primary responsibility was to maintain “the quality of patient care in the unit.” *Id.* at 816. Therefore, her supervisory duties were secondary, affording her protection under the NLRA.
121. *Id.* at 814 n.9. The A.N.A. Code, *supra* note 13, at 1792, stipulates that when factors in the health care delivery system threaten the welfare of the patient, “the practice should . . . be reported to the appropriate authority within the institution, agency, or larger system.”
to challenge her discharge for individual acts of patient advocacy.\footnote{726 F.2d 1346 (9th Cir. 1984) (citing 42 U.S.C. § 2000e-3 (1982)).} Wrighten complained to her superiors about alleged mistreatment of black patients and discrimination against black staff members. When her efforts proved unproductive, Wrighten held a press conference to protest black patient care at the hospital. Shortly thereafter an all-white committee was appointed to investigate the matter. Wrighten was subsequently terminated on the grounds that she did not cooperate with the investigation committee.\footnote{Id. at 1350.}

On appeal, the Ninth Circuit held that Wrighten had met her burden of proving that the hospital retaliated against her for engaging in protected activities.\footnote{Id. at 1357.} The court recognized the difficult position of nurses who challenge hospital administrations by stating that “[p]atient advocacy by a nurse is not insubordination.”\footnote{Id.} Thus, her actions did not exceed statutory protection and Wrighten prevailed on her claim of retaliatory discharge.

### III. ANALYSIS

#### A. Scope of the Problem

1. **Confusion in the Courts**

   Ethics must be distinguished from morality. Ethics focuses on the development of rational methods for choosing the best course of action among conflicting alternatives, whereas “morals refers to ‘action in accordance to rules of ‘right’ conduct.’”\footnote{ETHICAL ISSUES IN NURSING, supra note 19, at 210 (citing H. BRODY, ETHICAL DECISIONS IN MEDICINE 18 (1981)).} Ethical reasoning is a process that must be learned systematically in order to be applied consistently in varying factual situations. This requires formal education as well as actual experience in defining and resolving ethical dilemmas.\footnote{Huckabay, supra note 8, at 65.}

   However, while cautioning health professionals against confusing decisions made according to moral precepts with those made according to ethical considerations, courts have not provided usable guidelines to accomplish this task. In *Warthen v. Toms River Community Memorial Hospital*,\footnote{199 N.J. Super. 18, 26, 488 A.2d 229, 233 (1985).} the New Jersey Court of Appeals relied on the state supreme court’s dictum in *Pierce v. Ortho*
Pharmaceuticals to draw a distinction between the personal moral beliefs of the health care provider and guidelines promulgated by a professional code of ethics.

The court's decision that the etiology of the plaintiff's actions was moral rather than ethical, and therefore did not rise to the level of public policy, deprived her of a cause of action. More important, the court's failure to articulate standards by which this distinction is made fails to provide nurses with guidelines for future conduct, since Warthen's philosophical objection to continued kidney dialysis arguably fell into the realm of a responsible ethical decision.

The Illinois Court of Appeals in Free v. Holy Cross Hospital further blurred the distinction between ethical guidelines and moral beliefs when it defined morally controversial issues subject to protection under the Right of Conscience Act "as euthanasia, sterilization or abortion." By contrast, in Warthen the New Jersey court held that because plaintiff's moral convictions were for her own benefit, they did not rise to the level of public policy. Conversely, it implied that Warthen might have prevailed had she instead argued that her conduct, which was similar to that of plaintiff Free, was based on ethical considerations.

Furthermore, the Warthen court erroneously concluded that the plaintiff's reliance on the American Nurses' Association Code for Nurses was solely for her own benefit, when it stated that "[b]y refusing to perform the procedure she may have eased her own conscience, but she neither benefited the society-at-large, the patient, nor the patient's family." On the contrary, "the Code for Nurses is a policy document that constitutes the expression of principles that are geared to the enhancement of health care in general," rather than the personal well-being of individual nurses.

Due in part to conflicts created by the courts' imprecise conceptualization, "[t]he value of an ethics code provision in arguing a public policy exception in a wrongful discharge action is clearly limited to a supportive role, helpful in buttressing the public policy argument but not sufficient to sustain it."

Another barrier to successful use of professional codes of ethics as a basis for patient advocacy is the widespread insistence by the

129. 84 N.J. 58, 72, 417 A.2d 505, 512 (1980).
133. Id. at 12.
courts that the source of public policy be statutory. This requirement is largely due to a reluctance to identify and define broad concepts of public policy, "lest they mistake their own predelictions [sic] for public policy which deserves recognition at law." 134

Moreover, "courts do not concur on what constitutes public policy . . . [T]hey also disagree on the sources they are willing to use in applying the exception to the employment-at-will rule." 135 Indeed, the attempt to define public policy may defeat its effectiveness in protecting some of the more "nebulous societal values that are not . . . spelled out in a specific . . . statutory provision." 136 Clearly, the attempts of health professionals to use nonstatutory sources of public policy, such as professional codes of ethics, demonstrate the need for specific statutory authority to support acts of patient advocacy.

2. Institutional Dynamics

Although the importance of nursing advocacy may be formally acknowledged by health care institutions, it is basically at odds with the culture of the hospital system. Advocates must, therefore, tread carefully to avoid being labelled troublemakers. 137 Institutional dynamics tend to inhibit fellow nurses from supporting a difficult ethical decision of a colleague. The initial support of a colleague may be withdrawn in the face of administrative pressure to conform to the policies of the institution. 138

Thus, while it may be more effective to take action collectively, concerted action is often difficult to organize despite the protection offered by legislation such as the National Labor Relations Act. Moreover, few nurses possess the means or desire to engage in protracted litigation to protect their rights as patient advocates. The end result is that the patient pays the price for lack of administrative support for nursing advocacy.

The patient advocate is charged with recognizing the importance of good working relationships within the health care system.

136. Id. at 847 (quoting Comment, Brockmeyer v. Dun & Bradstreet: The Narrow Public Policy Exception to the Terminable-At-Will Rule, 38 U. MIAMI L. REV. 565, 587 (1984)).
137. Kohnke, supra note 20, at 2040.
138. See generally Smith, Outrageous or Outraged: A Nurse Advocate Story, 1980 NURSING OUTLOOK 624; Smith, supra note 48, at 18.
However, “occasionally all efforts to negotiate, compromise and persuade may be futile and . . . in the interests of protecting the patient the advocate must be willing to risk alienation of co-workers, employee/employer relationships, and career in the interests of ethical and moral convictions.”

B. Factors Calling for Change

1. Advances in Medical Technology

Scientific advances in modern medicine have created a situation of bewildering complexity for the average patient. The health care team has evolved to deal with the increased scope of medical knowledge. This specialization has, however, led to a fragmentation of medical care. The nurse is often the only consistent presence in the patient’s hospital environment. Nurses provide sustained and intimate care for the patient and are thus able not only to interpret the baffling array of unfamiliar procedures, but also to understand their impact on the patient as a unique individual. The nurse is, therefore, an ideal patient advocate due to both her sophisticated medical knowledge and high degree of patient contact. Conversely, the typical physician’s workload allows little opportunity for this level of interaction with the patient.

Technological developments allowing the artificial prolongation of life have engendered the need for decisions that were inconceivable a few years ago. Nurses complain that what can be done for the patient is asked more frequently than what should be done. This may cause significant frustration due to the consequences of the tasks the nurse is ordered to perform. For instance, in Barber v. Superior Court, although the physicians made the decision to deny intravenous fluids to a comatose patient, the nurses had to care for a patient dying from acute dehydration.

139. Robinson, supra note 4, at 59 (citing Zussman, Think Twice About Becoming A Patient Advocate, NURSINGLIFE 46, 50 (Nov./Dec. 1982)).
140. ETHICAL ISSUES IN NURSING, supra note 19, at 2. The fragmentation of medical care is especially evident in medical teaching facilities where patients are exposed to a depersonalizing barrage of ever-changing faces and procedures.
143. Corless, supra note 22, at 72.
144. Lagerlof, Nurses and Ethics, 9 CAL. NURSING REV. 12 (1987).
Situations such as this arise primarily because of the conflict between the physician's decision, usually based on sophisticated scientific criteria, and the nurse's decision, usually based on human values. Tensions arise because physicians often ignore the expertise of nurses when seeking solutions to ethical dilemmas generated by medical problems. However, "the nurse offers a philosophically different, but legitimate, perspective on patient care."  

2. Changes Within The Nursing Profession

The women's movement has been a major factor in the current expansion of the nurse's role. One author describes a virtual "revolution" since the late 1970's in nurses' self-image and willingness to make independent decisions. The result of this change is a reluctance to subordinate the patient's needs to those of the doctor and the hospital.

In 1981, a major nursing journal conducted a study of 12,500 nurses based on Tuma v. Board of Nursing, in which a nurse was sanctioned for discussing treatment alternatives at the request of her patient. An overwhelming eighty-three percent of nurses participating in the study supported Tuma's decision to act in what she judged to be the best interests of her patient. The approval of Tuma's actions was consistent despite differences in age, sex and educational level.

The nurses in the study articulated their duty as patient advocates. They reasoned that this duty, in combination with the patient's right to know, made Tuma's actions necessary and proper. Evidently, a large number of modern nurses are willing to accept the duty of patient advocacy.

Since the early 1970's, modern nurse practice acts have redefined nursing as an independent profession with a unique body of

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147. Id.
149. Murphy, supra note 146, at 174.
150. Sandroff, supra note 22, at 28 (citing Tuma v. Board of Nursing, 100 Idaho 74, 593 P.2d 711 (1979)).
153. BILL OF RIGHTS, supra note 16, at 1782 states "[t]he patient has the right to obtain from his physician complete current information concerning his diagnosis, treatment and prognosis in terms the patient can be reasonably expected to understand."
knowledge distinct from medicine. While medicine focuses on pathologic function in illness, "the focus of nursing [is] the patient's response to the health problem and the nursing needs which arise from such responses." "Within the realm of human responses to the health problems which nurses diagnose and treat, lie many quality-of-life issues."

However, the ethical mandate of a nurse may conflict with that of a physician because of these differing perspectives. "The number of . . . conflicts is increasing between the two professions, especially in the teaching hospital where acute care medicine is practiced." As nurses become more willing to speak out on ethical issues, "litigation may result unless nurses are intimately involved in patient care and institutional decision making."

3. The Chronic Nursing Shortage

The frustration of responsibility for patient welfare in the absence of authority to make decisions has contributed to the chronic nursing shortage. Nurses' desire to participate in health care decisions regarding their patients has been partly responsible for the well documented phenomenon of "burnout" in the profession.

154. Bullough, supra note 32, at 383; Murphy, supra note 146, at 174.
155. Murphy, supra note 146, at 174.
156. Murphy, supra note 146, at 175.
157. Murphy, supra note 146, at 175.
158. Murphy, supra note 146, at 175. Although whistleblowing statutes afford some protection to nurses who publicly voice their concerns, the better solution is to provide nurses with a stronger voice in the health care community to avoid outcomes such as litigation. See, e.g., N.Y. PUB. HEALTH LAW § 230(11)(b) (McKinney Supp. 1989), which provides that "[a]ny person . . . who reports or provides information to the board in good faith, and without malice shall not be subject to an action for civil damages or other relief as the result of such report."
159. Congress has studied the dimensions of this [nursing] shortage, as have hospital administrators and nurses. The Nurse Training Act of 1975 gave the Secretary of Health and Human Services authority to make grants to public and non-profit private nursing schools to help increase the supply of nurses. Even with these grants . . . there is mounting evidence to document the existence of a nursing shortage in all types of patient care settings.
Comment, supra note 49, at 118-19.

According to a 1980 study of member hospitals by the American Hospital Association, "there are between 90,000 and 100,000 vacant positions for nurses, with nursing vacancies in eighty percent of the nation's hospitals. In California, the number of full-time vacancies is over twenty percent with a turnover rate exceeding fifty percent." Comment, supra note 49, at 119. Ominously, "the number of vacant budgeted registered nurse positions nationally more than doubled between 1985 and 1986." Westfall, supra note 3, at 18.
160. The term "burnout" refers to the frustration nurses experience as a result of "their lack of a sense of selfworth . . . and their perception of poor professional interactions with
Studies done by the American Hospital Association in response to the severe nursing shortage of the late 1970's and early 1980's found that “nurses left the profession most frequently because of their inability to participate in the clinical decision making process in a meaningful way.”

The serious shortage of working nurses has led to widespread understaffing in hospitals, the effects of which “range from reducing the quality of care to actually jeopardizing patient safety.” Nurses have been held accountable for their failure to meet professional standards, even when working under unreasonable staffing conditions due to administrative decisions over which they had no control. A vicious cycle results as more nurses become dissatisfied because of their inability to meet legal and professional standards due to inadequate staffing.

C. Barriers to Role Expansion

Health care institutions typically fail to provide an atmosphere in which nurses are encouraged to participate in decisions regarding their patients. However, ethical decision-making requires the ability to arrive at conclusions that are not the mere result of moral intuition. Therefore, nurses' lack of input into ethical decisions denies them the benefit of the experience necessary to the learning process.

In addition, “notions of ethics committees and shared health care decision making challenge the tradition of physicians as lone decision-makers.” The confusion between the nature of medical

161. Murphy, supra note 146, at 174.
162. Murphy, supra note 146, at 174.
163. Comment, supra note 49, at 120.
164. For instance, in the case of In re Hagans, the California Board of Registered Nurses revoked the license of a registered nurse for delegating responsibility to unlicensed personnel for instilling routine ophthalmic medication in the eyes of newborns, in spite of the Board's finding that the department was badly understaffed and no injury had occurred. Westfall, supra note 3, at 31 (citing In re Hagans, BRN No. 79-14 (Cal. 1980)). See also Comment, supra note 49, at 125-26; Cushing, Staffing: Sometimes A No-Win Situation, 1986 AM. J. OF NURSING 389.
165. Murphy, supra note 146, at 174.
166. Huckabay, supra note 8, at 64; Theis, supra note 144, at 1224.
167. Murphy, supra note 146, at 173.
decisions and health care decisions contributes to physicians' reluctance to relinquish decision making power. Medical decisions are based on the doctor's special knowledge and clinical expertise. Problems arise because many physicians also claim the exclusive right to make health care decisions that deal with social values and which are thus nonmedical in nature.¹⁶⁸

Lack of time is a significant factor inhibiting the patient advocacy process. Aside from the obvious time constraints presented by emergency situations, heavy caseloads and the emphasis placed on task performance severely limit nurses' ability to reflect on issues with which they are confronted. Hospital administrators have a duty to provide opportunities for nurses to analyze and resolve ethical dilemmas.¹⁶⁹ However, the current trend toward cost containment is unlikely to allow staffing patterns that provide adequate opportunities for such philosophical introspection.¹⁷⁰

There are other problems inherent in the role of the nurse as patient advocate. The legal definition of advocate implies that someone has selected an individual to serve that function.¹⁷¹ However, under normal circumstances a patient cannot decide whether the nurse will act as his or her advocate. Therefore, the nurse may have to decide whether to function as protector of the best interests of the patient against the patient's own wishes.

Thus, there may be a conflict between the dual duties of protecting the patient and representing his or her best interests.¹⁷² Because of this potential conflict, advocacy may be psychologically very difficult for health care professionals. They tend to fall into the trap caused by the "rescuer complex," in which they assume they know what is best for the patient.¹⁷³ Such paternalism, however, is contrary to the patient advocate's fundamental duty to respect the patient's decisions, despite the nurse's own personal convictions. This conflict may, therefore, result in the need for intervention by an advocate between patient and nurse.

This raises the ultimate issue of whether the role of patient advocate should be assumed by nurses at all. "A patient's fear and pain, as well as forced dependency, exposure, and physical contact can make it extremely difficult for the nurse (who is usually a total

¹⁶⁸. Huckabay, supra note 8, at 62.
¹⁶⁹. ETHICAL ISSUES IN NURSING, supra note 19, at 77-78.
¹⁷⁰. L. CURTIN & M. FLAHERTY, supra note 5, at 164-65.
¹⁷¹. BLACK'S LAW DICTIONARY 51 (5th ed. 1979).
¹⁷². Abrams, supra note 21, at 264-65.
¹⁷³. Kohnke, supra note 20, at 2039.
stranger) to understand or appreciate the individual, not as a patient but as a person."174

In addition, as long as a nurse is dependent on the good will of her employer, there may be conflicts if she attempts to advocate a position of which the institution disapproves. In order to be effective, a patient advocate may need to be financially independent of the hospital. This would have the advantage of giving patients flexibility to change advocates at will, as well as ensuring primary accountability to the patient.175 This concept of patient advocacy would, however, inevitably limit nurses to a task oriented role that would be unacceptable to a majority of modern nurses.176

IV. PROPOSAL

A. Implementation of Patient Advocacy

The Ethics Committee of the California Nurses' Association advises nurses to avoid the common pitfall of self-righteousness and to attempt a collaborative rather than adversarial approach.177 The first step is to ascertain the patient's true preferences. Imposition of the nurse's own values on the patient must be scrupulously avoided to ensure that the decisions reached are consistent with the patient's beliefs.178

The nurse also has a duty to understand the legal ramifications of the situation, as well as the bioethical principles to be applied. Once this is established, the nurse should arrange a meeting with the patient's physicians to express her concerns. A face-to-face encounter is recommended.179

If the foregoing techniques are ineffective, the nurse is urged to persist in attempting to resolve the problem. Nursing colleagues, supervisory personnel and ethics committees should be enlisted.180 If the situation is still uncorrected, the American Nurses' Association recommends reporting to authorities such as practice committees of

174. Abrams, supra note 21, at 263.
175. Abrams, supra note 21, at 265-66.
176. One nursing theorist writes, "Nursing can and should be distinguished by its philosophy of care and not by its care functions." ETHICAL ISSUES IN NURSING, supra note 19, at 12. See also supra notes 150-53 and accompanying text.
177. Desmarais, Ethical Advocacy with Style, CAL. NURSE 7 (July/Aug. 1986).
178. As one nurse educator states, "Whatever patients define as their goal, it is their meaning and not ours, their values and not ours, and their living or dying and not ours." ETHICAL ISSUES IN NURSING, supra note 19, at 17.
179. Desmarais, supra note 177, at 7. According to one nursing commentator, "[A] wise word, well dropped, can make people retreat." Kohnke, supra note 20, at 2040.
180. Desmarais, supra note 177, at 7.
professional organizations and appropriate licensing bodies. 181

B. Legislative Measures

Case law demonstrates that nursing advocacy must be specifically recognized and supported by statute. Until there is legislative acknowledgement of the nurse’s need for protection in her role as patient advocate “the nurse continues to risk her career and her license as she pursues the ethical mandate of advocacy.” 182

Amendment of existing nurse practice acts is preferable to enactment of freestanding statutes. Amendment of current laws governing the professional conduct of nurses will decrease the potential for misapplication, as well as provide the clear mandate of public policy required by the courts.

A widely acknowledged code of ethics, such as the American Nurses’ Association Code for Nurses, should be used to clarify the basis for distinguishing between moral and ethical decisions. This requirement is essential, since the courts must be able to apply consistent guidelines to equitably determine the conduct to be protected by ethical decision-making legislation, as opposed to more general laws directed at protecting rights of conscience.

Language such as the following, prohibiting penalizing nurses who make responsible ethical decisions regarding patient care, should be incorporated into each state nurse practice act.

Each nurse has a duty to protect the ethical and legal rights of all patients. Each patient has the right to determine what will be done with his or her person; to be given information necessary for making informed judgments; to be told the possible effects of care; and to accept, refuse, or terminate treatment. These rights apply to minors and others not legally qualified and must be respected to the fullest degree.

The nurse shall fulfill this obligation by working with the patient and others to arrive at the best decisions dictated by the circumstances, the patient’s rights and wishes, and the highest standards of care. The imposition of the nurse’s personal moral or religious values on the patient shall be scrupulously avoided to ensure that the decisions reached are consistent with the patient’s individual beliefs.

The nurse shall not be penalized for such reasonable good

181. A.N.A. Code, supra note 13, at 1792.
182. Robinson, supra note 4, at 62.
C. Judicial Measures

The duty of patient advocacy should be supported through penalties for those who breach, or cause others to breach, this responsibility. A cause of action for wrongful discharge should be recognized against those who willfully prevent or punish acts of advocacy in violation of the mandate of the particular state nurse practice act. Judicial recognition that the ultimate beneficiary of nursing advocacy is not the nurse, but the patient, will further the important public policy underlying the patient's right to self-determination.

D. Collective Bargaining Measures

Every hospital stands to benefit from an ethics committee on which nurses are represented. Such representation is important since the nurse, as the provider of total patient care, has a valuable contribution to make in weighing the burdens and benefits of a plan of treatment. Recognition of the duty of patient advocacy must be supported by the collective bargaining unit of which the nurse is a member. It is uncommon at present for collective bargaining agreements to provide for nurses' rights to participate in ethical decisions.184

In order to be effective, this right must be enforced by provisions for a structured dialogue between the nurse and the hospital administration when problems develop. This can be accomplished either by setting up a formal grievance procedure, requiring the matter to be submitted to an ethics committee, or by arbitration. If an ethics committee exists, the collective bargaining unit should negotiate for strong representation on it by nurses.

E. Educational Measures

The importance of informed ethical decisions should be supported by continuing education for working nurses. California, for

183. Adapted from A.N.A Code, supra note 13, at 1.1, 1.6.
184. Many collective bargaining agreements set up professional performance committees to make recommendations to administration regarding nursing practice. They may also address the right of nurses not to participate in abortions. However, generally there is no specific language supporting the right of nurses to participate in making ethical decisions. See, e.g., Agreement between Stanford University Hospital and the Committee for Recognition of Nursing Achievement, 1986-1988; Memorandum of Understanding between the Registered Nurses Professional Association and the County of Santa Clara, 1986-1988; Memorandum of Understanding between El Camino Hospital and Professional Resource for Nurses, 1984-1986.
example, requires that nurses obtain at least thirty hours of continuing education every two years in order to qualify for relicensure. Due to the trend toward expansion of the nursing role, nurses offered the opportunity will undoubtedly be eager to learn methods of implementing patient advocacy. Providers of continuing education will realize the economic potential of developing courses in response to a legislatively defined mandate for ethical advocacy.

V. CONCLUSION

Medical technological progress continues to create increasingly complex ethical problems. A sophisticated level of awareness is needed to develop constructive solutions. Because of her high degree of patient contact and medical knowledge, the nurse stands out as the health care professional most suited to the role of patient advocate. Nurses, with their emphasis on human values, are in an ideal position to contribute to controversial treatment decisions and evaluate their impact on individual patients.

Nurses welcome the responsibility and accountability concomitant with the status of nursing as an independent profession. They have expressed their dissatisfaction with the reluctance of physicians and institutions to allow their input into decisions regarding their patients by leaving the profession. This has created a widespread severe shortage of nurses, often to the detriment of the patient population.

Legislative, judicial and administrative support for ethical decision-making will benefit both the nursing profession and the patients, who are the consumers of nursing care. In addition, physicians and health care institutions stand to gain much from the insight that nurses bring to the delivery of total patient care.

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