

Legality, morality and reality - the role of the nurse in maintaining standards of care

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ABSTRACT

Objective

This paper explores the legal and ethical frameworks that inform nursing practice and health care cultures. Using methodologies informed by critical race and feminist jurisprudence (also called 'outsider scholarship'), images of nursing and the positive and negative effects of these images and their legal, moral and ethical impact on nursing practice, are explored. This exploration assists in exposing some of the power structures and assumptions which govern contemporary nursing practice and standards of care and which impact on factors such as workforce retention.

Setting

Applies to all settings in which nurses' practise.

Subjects

Nurses, other health care professionals and patients

Primary argument

Examples from case law are used to illustrate the relationship between image and power and how these affect legal and moral frameworks and the realities of the workplace for nurses. This is done by examining the law, as a form of insider (whereby the world is described in terms of pre-existing power structures) and outsider story-telling (whereby stories are challenged to reflect experiences). Five dominant and recurrent images of nursing emerge from case law analysis. These have implications for: the way in which nurses respond to critical situations which involve the adoption of a moral stance; nurses' legal and ethical status, and; the environment in which nurses' practise.

Conclusion

Each of the images of nurses described in this paper is still present in both recent case law and workplace practice. These images have deleterious effects, most particularly contributing to feelings of powerlessness in the workplace and affecting nurses' ability to be 'heard' when patient safety is at stake. While some images give the nurse a degree of moral (and clinical) responsibility, there is no promise of power.

Both the inability to influence patient care and an unmet need to feel valued and appreciated contribute to nursing workforce attrition. A complex mix of solutions needs to be implemented to achieve improved workplaces, patient outcomes and retention rates. The promotion of a safety and quality agenda; promoting strategies for self care; well developed clinical career paths; implementing clinical supervision, and introducing Magnet organisation reform, are among the important solutions for addressing these issues.

INTRODUCTION

This article explores the legal, moral and ethical frameworks that inform nursing practice, how these have shaped and been shaped by images of nursing, and the positive and negative effects of these images of nursing. Case law is used to illustrate the points raised and suggestions are made to help bridge the gap between legality, morality and workplace reality for nurses.

The legal frameworks that inform nursing practice include the provisions within registration statutes, codes of conduct and other advice through registering authorities; civil requirements in common law and statute law; industrial requirements and sanctions and criminal sanctions. Moral and ethical frameworks are enshrined in professional codes of ethics and also in normative ways that have developed in response to historical and sociological developments such as the 'ethic of obedience' (Chiarella 1990); the 'ministering angel' ethic (Chiarella 2002) and the 'tyranny of niceness' (Walker 2003). Walker describes the 'tyranny of niceness' thus:

The pre-eminent value inherent in the technique of sensibility of 'being nice' is one that insists that overt conflict must be avoided wherever and whenever possible. This sensibility is sanctified in our culture in the notion that a good woman does not contradict and a nice woman does what she is told. By extension then, a good nurse takes what she finds (or is given) and does not question. A nice nurse therefore must be a good nurse (Walker 2003 p.4).

The behaviour this technique initiates is one of backing off, assuming a passive posture, or silencing oneself. It is a technique of sensibility which shapes (us) in pervasive and powerful ways. The reciprocal behaviour such a technique of sensibility elicits is one that is generally tacit; it does not usually ever come to expression. The combination of value, behaviour and response leads to a form of silent but mutual agreement between the individuals engaged in the conflict situation...it gently insists that no further dialogue is needed to resolve the situation (Walker 2003 p.145).

The 'tyranny of niceness' and the images of the nurse described below have influenced the legal, moral and ethical frameworks that have developed in nursing and most particularly contribute to feelings of powerlessness in the workplace and affect the nurses' ability to be heard when patient safety is at stake.

DISCUSSION

Images and stories of nurses with reference to case law

A study analysing the status of the nurse in law, society and scholarship using methods grounded in critical race and feminist jurisprudence, known as forms of outsider scholarship, examined 180 cases from 1904 to 2002 (Chiarella 2002). In this study, the law is described as being about storytelling, with stories created by insiders (stock stories), who describe the world according to their own power structures, and by outsiders, who try to challenge these stories to reflect their own experiences (outsider stories). A stock story is defined as:

'...the one the institution collectively forms and tells about itself. The story picks and chooses from among the available facts to present a picture of what happened: an account that justifies the world as it is' (Delgado 1989 p.2421).

Where stock stories reflect accounts that '*... makes sense, is true to what the listeners know about the world, and hangs together*' (Scheppelle 1989 p.2080), outsider stories are those which are told '*to attack and subvert the very institutional logic of the system*' (Delgado 1989 p.2429) and which provide a means to expose '*the perceptual fault lines*' (Scheppelle 1989 p.2082). Outsider stories can be seen as troublesome, upsetting or interfering and the natural tendency is to ignore them because the established order already works very well for those in power.

Five recurrent images emerged from the case law analysis and, it is argued, these provide the backdrop for the ethical and legal practice frameworks that have developed in nursing. These images are: domestic worker; ministering angel; doctor's handmaiden; subordinate professional

and autonomous professional. These images provide themes as stock and outsider stories and are classified accordingly. Firstly, as stock stories, in which nurses are under control. The associated images are the nurse as a domestic worker; doctor's handmaiden; and subordinate professional. Secondly, as outsider stories (nurses are in control); the nurse as a ministering angel or autonomous professional.

Outsider stories and their effects on nurses' legal, moral and ethical status

For the purposes of this article, outsider stories are used to illustrate the effects of stories on nurses' legal, moral and ethical status. The ministering angel was the earliest outsider story and is full of ethical resonance. It was fostered by Florence Nightingale to counteract the Sarey Gamp image, the image of the drunken and disreputable nurse described by Charles Dickens, who was a danger both to herself and the households she visited (Dickens 198). This image of the ministering angel served nurses well in a Victorian 'man's' world enabling them to maintain propriety in order to conduct the professional experiment of 'respectable' women at work, and to some extent it still serves nurses well in terms of public relations. However there are downsides to this 'ministering angel' story which negatively impact on nurses and nursing. These include the fact that nurses tend to be essentialised as nun-like creatures; which in turn creates the public view that 'virtue is its own reward'; which in turn instils within it concepts of self-sacrifice; creates an environment of permission to suffer and maintains the notion of a 'cloistered' profession kept away from the 'real' business of the health care world (Barber and Shadbolt 1996).

The idea of the nurse as an autonomous professional began with Ethel Bedford Fenwick in 1908, who stated that: '*the nurse question is the woman question*' (cited in Dock and Stewart 1938 p.254). The features of this story are that it originally addressed the pursuit of professional equality through a 'sameness' model (MacKinnon 1987 p.33); it sought to break free from doctor's handmaiden and subordinate professional images through the pursuit of autonomy

in self-regulation, self-management and the setting of professional and educational standards (Chiarella 2002). This autonomous professional image has been the genesis of both the regulatory and industrial framework in which nurses practise and has been arguably quite successful in establishing the autonomy of the profession and in the setting of standards.

However the main downside of this story is that this model has been pursued without redress to the power imbalances in the way in which health is structured. It has not addressed (and may even have perpetuated) the cultural problems, such as institutionalised powerlessness, which affect retention (Chiarella 2002). Nor has it met the need to foster confidence and promote innovation within the profession. It has also been focussed predominantly on nursing, rather than health (Chiarella 2007 p.41). Each of the images described here are still present in both recent case law and workplace practice to some extent; the examples below demonstrate the effect exerted by these images.

Factors which influence nurses' ability to deliver quality patient care

Thirty years of research has consistently found two reasons why nurses leave the profession. The first is they feel unable to deliver the quality of care they believe is required and the second is they feel they are not valued or respected (Chiarella 2002 p.344). The factors which influence nurses' ability to deliver quality patient care are: a multidisciplinary team approach to patient care delivery (this is well embedded in the safety and quality agendas); the ability to provide care which satisfies nursing and patient expectations; a formula to ensure reasonable workloads (which ought only to be a short-term solution) and a work environment which fosters nurse autonomy and control over practice in order to provide safe patient care (Duffield et al 2007).

A multidisciplinary team approach and the recognition of nursing expertise through clinical career paths are also important. Recently there has been a body of international research that suggests that skill mix changes generally require a change of role for

nurses rather than for other health care professionals but that this occurs with no increase in nurses' autonomy (Duffield et al 2007). One of the results of this situation is that: *we can only imagine what it has done to the psyche of our profession only to be financially rewarded for not practising clinical nursing* (Chiarella 2007 p.38).

Other issues to be addressed include the need to attend to power imbalances and the need to have a system based on practice expectations, not personalities. Because nurses can be seen concomitantly as both advanced practitioners and as subordinate to doctors, this creates a level of uncertainty and ambiguity in terms of nursing's role. Power imbalances in workplace culture thus needs to be addressed from both a medical and nursing perspective because: *power at its peak becomes so quiet and obvious in its place of seized truth that it becomes, simply, truth rather than power* (Matsuda 1990 p.1765). Such imbalances are amply illustrated by examining some examples from case law.

Addressing the power imbalance from a medical perspective

There are several cases which demonstrate that the only strategy nurses still possess to influence patient care in situations of concern is to bring a problem to the attention of doctors. They cannot force doctors to act. Cases such as *MacDonald v York County Hospital and Dr Vail* (1973) and *Bolitho v City and Hackney HA* (1998), both of which were focused on the legal question of causation - that is the person's action or inaction directly caused the harm to the patient, only serve to highlight the nurses' dilemmas. The patient in the first case lost his leg; the child in the second case suffered catastrophic brain damage. In both cases, the nurses had expressed their concerns about the patient on a number of occasions. In both cases, the doctors did not respond to the nurses' concerns, originally in MacDonald and repeatedly in Bolitho.

In MacDonald, the nurses were found not to be negligent on grounds of causation. In Bolitho, although the doctors' failure to attend was found to be a breach of duty, they were found not to be

negligent. In both cases the finding of no negligence was because the doctors gave evidence they would not have altered their treatment even if they had seen the patients. In both cases the doctors did not see the patients until it was too late to even attempt to prevent the damage occurring. Both cases were determined by the judges without comment as to the distress and difficulties the nurses might have experienced, both in terms of trying to contact the doctors and afterwards in the knowledge they had been powerless to reverse the course of events.

In *Re Anderson and Re Johnson* (1967) and the *Inquest touching the death of PDP* (1994), the fact that doctors failed to take action on the expressed concerns of the nursing staff similarly elicited no comment. Both these patients died.

In each of these four cases the nurses expressed their professional, clinical opinions to the doctor on the patients' conditions. In the first two cases, the doctors gave sworn evidence to the fact that, regardless of the outcomes, they would not have heeded the nurses' concerns and changed the treatment. In the latter two cases, the facts emerged that the doctors manifestly ignored the nurses' concerns and continued on their clinically determined route to the detriment of the patient.

Such power imbalances impact on patient safety because nurses are unclear as to their rights and responsibilities. They cannot compel doctors to act. These dilemmas are known to impact on retention of nursing staff (Aiken 2006). Lessons from the safety and quality agenda may assist in addressing issues of power imbalances in health care culture that affect patient outcomes. These include: learning from the aviation industry; the work of James Reason in human factors and the concept of 'graded assertiveness' (Runciman et al 2007). Human beings make mistakes (Reason 1990) and health care professionals are no exception (Brennan et al 1991). The aviation industry has undertaken a considerable amount of work in this area and has developed the concept of crew resource management. This includes concepts such as graded assertiveness, which creates the imperative for each member of the aviation team to

speak out forcefully if they consider there is a problem through a process of escalating their concern (Flight Safety Foundation 2000). Such an expectation is an imperative for health care practice if cases such as the ones discussed above are to be avoided. There needs to be provision made for some form of intervention which is instantly recognisable to both doctors and nurses as a 'major clinical dispute procedure'. It could only be invoked if the nurse considered on reasonable grounds that the patient's life or wellbeing was in serious danger. A refusal to acknowledge and act on the nurse's concerns in such a situation should carry significant sanctions for medical personnel. This would provide the nurses with some framework within which to operate and would provide some legitimate recognition of their moral authority and help to overturn both the ethic of obedience and tyranny of niceness that act to constrain the individual from challenging medical authority (Chiarella 2002).

Addressing the power imbalance from a nursing perspective

Examining the power imbalance from a nursing perspective often relates to workload and its concomitant stress. *I knew I was too tired to take care of the sicker patients but you can't speak out - you are seen as a whinger* (ACSQHC 2003 p.12). Similarly there is a need to address horizontal violence - the oppression of nurses by nurses, a characteristic of groups who perceive themselves to be oppressed or powerless which has its genesis in the socio-pathology of oppressed groups (Fanon 1963). *I was pretty sure it was the wrong dose - it just seemed too much for the patient - but when I tried to say something I was told "What would you know - you're all the same straight out of university and you think you know more than the rest of us"* (ACSQHC 2003 p.12).

Proposals to address workload issues include having strategies for review of workloads such as the Reasonable Workloads Committees in NSW (NSWNA 2004) and ongoing solutions such as workload research (Duffield et al 2006). Duffield et al (2007) found nurses were more likely to be satisfied with

nursing if they experienced positive leadership and autonomy and control over their practice. Addressing the impact of the socio-pathology of oppressed groups on workplace culture and the associated issue of horizontal violence is also needed (Chiarella, 2002).

Thirty years of research on why nurses leave the profession reveals two key reasons - a sense of not being valued and a perceived inability to influence the quality of care the patient receives (Chiarella 2002). There is therefore a need to ensure that nurses feel valued and there are many strategies that can be employed to address this. These include developing strategies for self-care (Skovholt 2000); the availability of clinical supervision to enable better management of 'unfinished clinical business' when nurses have been involved in adverse events where they have felt unable to influence the course of the outcome; improved and coherent clinical career paths so that nurses are appropriately and consistently rewarded for practising clinically; and Magnet organisation reform, which is discussed below.

Correlation between retention and patient outcomes

The research evidence demonstrates that changes to cultures, professional expectations and roles result in improved patient outcomes. In the 1980s, the American Academy of Nursing (AAN) conducted a study of USA hospitals to identify the organisational attributes that were successful in recruiting and retaining nurses during a national nursing shortage. The top hospitals shared certain measurable characteristics, each of which was predicated on recognition of nurses' contribution to patient care and the environment of the facility. These organisations were described at that time as Magnet hospitals.

The characteristics of a Magnet organisation are effective and supportive leadership; nursing staff involvement in hospital decision making; commitment to professional clinical nurse qualities; participatory management; autonomy and accountability; and a supportive environment (Buchan 1999). The hospitals which consistently sustained these characteristics not only had significantly higher

retention rates than other similar hospitals (Aiken et al 2002); they also demonstrated significantly lower medical mortality rates and significantly improved patient outcomes. Adverse patient outcomes measured in the international research which were positively influenced by the introduction of Magnet hospital status include injuries from falls, medication incidents, pressure ulcers, post-operative pneumonia and urinary tract infections, gastro-intestinal bleeding, failure to rescue and death (mortality rates) (Aiken 2006; Aiken et al 2002). Yet to this day these extraordinary findings have not become the foundation for organisational reform in Australia. This suggests that the way power relations have evolved and how they have been maintained over the decades have ensured that health care delivery is firmly ensconced within a largely biomedical paradigm (Lupton 1994).

CONCLUSION

The legal and ethical frameworks that inform nursing practice have both shaped and been shaped by images of nursing. The effect of these images, contribute to feelings of powerlessness in the workplace and affect nurses' ability to be heard when patient safety is at stake. Exploring the often inconsistent images and roles of the nurse through 'stories' told in court is one way of examining how these stories are reflected in the working relationship between doctors and nurses and consequently contribute to cultures which are characterised by power imbalances and lead to an increased likelihood of diminished patient outcomes and work dissatisfaction.

The examples from case law illustrate that often the only strategy nurses possess when they are concerned about a patient is to bring the problem to the attention of doctors. However while some images give the nurse a degree of moral (and clinical) responsibility, there is no promise of power. Even contemporary images of nursing as 'autonomous professional' are problematic. For example, nursing has favoured this model without considering any power imbalances in the health system and it does not

address (and in doing so may even have perpetuated) the cultural problems which affect retention. While nursing images change, the same power structure dominates.

To bridge the gap between legality, morality and reality requires a complex mix of solutions. This includes fostering the ability to influence patient care and feeling valued and appreciated in the workplace. But the end result is worth it. The data demonstrates that addressing cultural factors improves retention of nurses and will significantly improve patient outcomes.

RECOMMENDATIONS

To address the issues described above the following suggestions are proposed:

- the promotion of a safety and quality agenda that honours and recognises the right of nurses to challenge practice and to be heard when they do;
- promoting strategies for nurses to engage in self-care within the workplace;
- establishing well-developed clinical career paths that provide consistent and coherent rewards for clinical nursing work;
- providing clinical supervision to assist nurses to address the psychological effects of adverse events; and
- a commitment to the implementation of Magnet organisation reform.

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