
Nurses as tools: Instrumentality and implications for nursing ethics

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Abstract

This paper examines the ethical implications of nurses as tools, that is nurses carrying out the delegated or instrumental work of others. It is proposed that nursing's instrumental relationship with medicine, has in some instances led to an ethos, or moral climate which legitimises excluding nurses and patients from moral decision making and silences the moral voice of nursing. Nursing's involvement with compulsory psychiatric treatment is examined as a particularly problematic area of practice in terms of the legal requirement to carry out "doctor's orders" and exclusion from dialogue about the terms of treatment. Treating nurses as mere tools is challenged as unethical and the facilitation of a new health care ethos founded on values of collaboration, relationship and inclusion is proposed as a moral imperative for ethical health care.

Amidst a rapidly changing social, political and technological landscape, nurses may at least hold on to the certainty that they are needed. Nursing is essential to the provision of modern health care, despite it being long recognised that nurses themselves have difficulty articulating responses to questions such as 'what is nursing?' and 'what is the unique area of responsibility of the nurse?'. At some time most people will need nursing but nurses are frequently needed to fulfil a range of roles beyond the provision of nursing care. In one sense, nurses are the 'tools' of others. Liaschenko (1997) described nursing as being 'instrumental' to the ends of medicine. Indeed much of what counts as nursing work is instrumental to the ends of many groups and this has profound implications for ethical nursing practice and ethical decision making in practice.

The purpose of ethics

As a generic term ethics refers to the various ways of understanding and examining the moral life (Johnstone, 1999, p. 42). The field of ethics has been described as "...the basis for choosing the kind of professional life we believe we should lead, so that we need not look back with regret in the future" (Barker, 1999a, p.199). The practical purpose of ethics should be to provide guidance to the nurse on the 'right' course of action in a given situation. Seedhouse (1988, p.90) suggests that a willingness by health workers 'to do the right thing' or 'to be moral' is insufficient to ensure ethical practice, that people need tools in the form of an understanding of ethical theory and philosophy to guide and justify their actions.

Traditional principle based approaches to ethical problem solving requires the weighing up of abstract principles from a position of detachment from the situation. Spreen Parker (1990, p.37) suggests that dialogue between people concerning their individual needs, desires and values is seen to threaten the impartiality required to make principle based decisions and, "... moral reasoning is confined to an abstract monologue, rather than a relational, embodied dialogue between

human beings struggling to make sense of deeply perplexing situations." At least some nurses have suggested that traditional approaches to ethical problems are antithetical to the practice of nursing founded on an ethos of care, which stresses involvement and the highly contextualised nature of human relations (Kurtz & Wang, 1991; Tschudin, 1992).

Connection with, rather than detachment from people is a primary and fundamental way of being in the world and an orientation of connection reflects a feminine 'voice' which has been silenced through traditional ethical discourse (Gilligan, 1995). Johnstone (1995, p.10) goes further by suggesting that mainstream bioethics is ethnocentric and sexist in nature and has "...only limited practical value and application in the realms of clinical practice in the health care arena". An evolving ethic of care (Simms & Lindberg, 1978) and feminist approaches to ethics (Sherwin, 1993) offer different lenses to examine the nature of ethical problems, and prescribe factors other than principles, for example relationships and institutionalised oppressive structures that require consideration in ethical enquiry.

Traditional approaches have failed to achieve the purpose of ethics for nurses. Nurses have shown themselves as more than capable of analysing situations in terms of conflicting principles, such as autonomy and beneficence in psychiatric nursing practice (see: Forchuk, 1991; Lützén & Nordin, 1993). However, there is little evidence to suggest that the capacity to do so has led to increased ethical behaviour. A substantial body of research on nursing and ethical decision making continues to describe behaviour, which is readily able to be challenged from a principle based approach to ethics (Fisher, 1995; Lützén, 1998; Lützén & Shreiber, 1998; Mohr, Mahon, & Noone, 1998; Morrison, 1990; Olofsson, Gilje, Jacobsson, & Norberg, 1998; Olsen, 1998; Rogers & Kashima, 1998). An increased awareness of situations as ethically problematic has not addressed the problem which Yarling and McElmurry (1986) highlighted, that is that nurses are constrained from exercising free moral agency. In part, this can be explained by consideration of the instrumental nature of nursing.

Nurses as tools

Modern nursing has, is and will continue to be defined by its relationship with medicine. As even a child is likely to observe, 'doctors and nurses' go together like a hand to a glove. Indeed, the most obvious characteristics which define nursing as distinctively different from other allied health professionals are sufficient knowledge of medicine to be able to assess medical status, report on medical symptoms, and assistance in the provision of medical care. The nurse in many instances becomes the eyes and ears of medicine (Liaschenko, 1998). Nursing is in a real and tangible way a tool of medicine, although it is not the only contribution that nursing can or does make to others.

An historical overview

Our nursing forebears were well aware of nursing as instrumental or complimentary to medicine and the perceived virtues necessary to fulfil instrumental roles. A popular nursing text in 1921 highlighted the "...importance of discipline, obedience to those who are set over her, perfect loyalty to the doctors with whom she works, and to all her colleagues. To discuss the doctors, the matron, and the other nurses, is not only mischievous, but it is a breach of discipline, of loyalty, and, indeed, of good manners" (Watson, 1921, pp.78-9.). The

authorised nursing manual of the St John Ambulance Association (St. John Ambulance Association, 1958, p.14) advised that the nurse had a duty to "...observe absolute obedience to the doctor, carrying out his instructions correctly in every detail". This required a degree of education in the realms of medical knowledge, which was frequently provided by doctors.

Crawford (1968, p.2) asserted that "A well trained doctor's nurse-receptionist can assist the doctor in many ways, and so save his precious time". The would-be "doctor's nurse receptionist" that this training manual was written for would have been well aware of her status as assistant to and employee of the doctor. The preface to the manual stressed "complete loyalty" to the doctor and the necessity to extend the basic knowledge of the "girl" in the tradition of Nightingale, so that the nurse could "...interpret the doctor's instructions with an intelligent obedience" (Crawford, 1968, p. ix).

At the turn of the twentieth century, Dock (in Yarling & McElmurry, 1986) observed that the complete subordination of the individual nurse to the work of the whole is as necessary for her as for a foot soldier. This analogy highlights the instrumental nature of nursing to the institution, and an ethos, which permeates to this day in modified form. Rodgers (1985) coined the term "Nightingale Ethos" to describe the values of nurturance, endurance, forbearance and obedience which formed part of the moral education of nurses and reflected Victorian notions of the virtuous woman. A functionalist sociological approach asks whether certain occupations require to be practised in a particular way in order to be socially useful (Campbell, 1988). From this perspective, "perfect loyalty" and "obedience" may be desired (if not required) of nurses, if nursing is merely a tool of medicine and the health care institution.

The nursing ethos founded on an instrumental relationship with medicine

Nurses of course are not 'merely' tools of anyone but an ethos persists which is founded on this assumption. Häring (1972) describes an 'ethos' as those distinctive attitudes, which characterise the culture of a professional group, and includes a definite tradition, a sharing of customs and common experiences, and commitment to a particular system of values. The ethos of nursing is entwined with, shares aspects of, and supports the ethos of medicine.

Nursing shares a common broad purpose with medicine to improve the health and wellbeing of people. Seedhouse (1997) argues that there is little difference between care ethics, medical ethics and nursing ethics based on this shared purpose, and argues that all ought to commence from a philosophy of health. This argument is however spurious in that the ethos of nursing is different and is founded on particular instrumental relationships with others, history and position within health services. A nursing ethic to have any practical use must be concerned with illuminating the nursing ethos and providing tools to the nurse to enable his or her to exercise moral agency. It may be argued that nursing is constrained by an ethos of subjugation which gives rise to observations such as "...if one speaks critically or takes a questioning stance then one is positioned as disloyal, ungrateful and a bad nurse" (Alavi & Cattoni, 1995, p.344). Nursing ethics must contend with the problem of many nurses having little if any voice in ethical decision making, and the problems of negotiating ethically problematic situations where the contributions and concerns of nursing are rendered invisible (Liaschenko, 1997; Liaschenko, 1998).

All care, no responsibility?

Clearly, the degree of instrumentality inherent in nursing work varies, as do the problems of constrained moral agency. However, the potential for nurses to be ethically compromised is high when working with people receiving compulsory psychiatric treatment. Medical doctors are charged with the legal responsibility for determining whether a person is mentally ill, in need of compulsory treatment and the nature of that treatment. These are profoundly ethical decisions, which are often couched as "diagnostic" decisions or "clinical judgements". Because of a medical ethos, which holds that "diagnosis" and "clinical judgement" are the primary domain of medicine, it is easy for nurses and others to be excluded from "treatment" and hence ethical decision making.

In relation to compulsory medical treatment nurses are required to contain the person, administer treatments, and report on treatment effectiveness. This is highly skilled and necessary work but can become ethically problematic for nurses when the clinical judgement of nurses come into conflict with the clinical judgement of medicine. Nurses are cognisant that the legal responsibility for 'treatment' rests with the doctor. A recently published synopsis of Mental Health Law in New Zealand (Bell & Brookbanks, 1998), highlights that psychiatry refers to 'medical practice' and compulsory treatment is negotiated and moderated through legal and psychiatric discourse. Nursing does not rate a mention and it may be assumed that nursing is subsumed under the umbrella of psychiatry. The person who is detained and subject to compulsory treatment may also be subject to compulsory nursing, the terms of which legally fall within the authority of the treating doctor. Nurses most definitely have a responsibility and are likely to be held accountable for their care of the compulsorily assessed person, but in practical terms they have little real responsibility for dictating what needs to be undertaken.

For the most part, nurses in practice acknowledge and accept the instrumental nature of nursing. In a study which examined the self-perceived roles of community psychiatric nurses (CPNs), the most frequently cited roles were assessment, counselling, medication and giving physical care (Barratt, 1989). Barratt (1989, p.44) suggested that these self perceived roles "... reflect the consultant's views of what CPNs do and may, therefore reflect the model of illness preferred by the consultant". The nurses in this study identified different reasons for assessment, such as "to find out what problems the client has with a view to solving them", however assessment "for the benefit of doctors" was most often cited (Barratt, 1989, p.44).

The position of nursing as instrumental to medicine is not in itself problematic, indeed it reflects an inter-dependency, which is characteristic of many complex human endeavours. It can however, lead to problems as nurses attempt to assert aspirations towards professionalism or assert a nursing point of view. Porter (1990, p.47) has said that, "...it is impossible for nursing to achieve the full autonomy required for true professionalism. Nursing will continue to be subservient to medicine because there is no way that medicine is going to give up its jealously guarded monopoly over diagnosis - and this defines that profession's relationship with its patients and with allied occupations." The term 'subservient' implies "serving as means" or "merely instrumental" in relation to others (Sykes, 1982). Given that nursing has and will continue to have an instrumental relationship with medicine, the challenge remains for nurses to negotiate the instrumental aspects

of their relationship with medicine in a way which emancipates rather than subserves nursing and patients.

Implications of nursings' instrumental relationship to medicine for ethics

That nursing is at times "subserviant" to medicine, is an unethical state of affairs. According to Seedhouse's (1988, p.98) interpretation of Immanuel Kant's categorical imperative "... it is always wrong to treat people as if they are objects - mere tools to further your own ambitions and ends". From this perspective, it is immoral to conceive of, or use nurses as "mere" tools, rather nurses should be recognised as having their own purposes. According to Kantian philosophy, all people are entitled to the same opportunity to make moral decisions (Seedhouse, 1988). Ethical health care would require that all people who have an interest in a decision be treated as equally morally competent. However, there are practical as well as philosophical problems with such a stance.

The Kantian notion of morality is focused on the rational being (MacKlin, 1982) and someone who is unable to reason from this point of view is unable to possess free moral agency or be held to account for their actions. To become subject to compulsory psychiatric treatment a judgement is made by psychiatry that the person lacks rationality in some sphere of decision making because of mental illness. The person is often said to "lack insight" or understanding of their situation, that is the person does not view their experience and situation in the same way as psychiatry - a symptom of illness amenable to medical treatment. When the person acknowledges that they are mentally ill and acquiesces voluntarily to medical treatment they may be said to "have insight". As mentioned the determination of such questions rests with psychiatry, which claims specialist knowledge or insight into the human condition, and a legal mandate to lend authority to psychiatric judgements.

Diminished rationality, lack of insight and an assessment of a person as dangerous to self or others (Fisher, 1995) serves as a justification for forced medical treatment. Medical discourse (Foucault, 1973) tends to privilege certain types of knowledge and a particular view of human experience. By dint of this specialist knowledge and insight which medicine is presumed to have, and the reality of major ethical decisions being associated with clinical judgement, it is easy to see that there exists a perceived hierarchy of moral competence. Medicine is often presumed to have greatest competence in moral decision making, followed by other groups such as nursing who have some, but a lesser understanding (partial insight) of medical knowledge, and lastly by the patient who is deemed to have the least competence.

Nurses are left in a particularly compromised position when required to administer compulsory treatment. The task of administering the treatment is often left to nurses who are legally required to follow "doctor's orders". There is little room for conscientious objection by nurses, as a moral objection is perceived as a challenge to the clinical judgement of doctors and the ethos of psychiatry. That nurses must 'do as they're told' in relation to the compulsorily detained and treated person does not, however diminish their personal moral responsibility for their own actions. According to the Kantian notion of moral agency, every rational being is responsible for their actions as all people are presumed to share the ability to reason morally (Seedhouse, 1988, p.102). Even from a consequentialist perspective, the individual actors still carry some moral culpability for their actions

based on actual consequences. The soldier who drops an atomic bomb may find some moral justification by asserting that doing so ultimately shortened a war and overall reduced suffering, but stating "I just followed orders" is insufficient. The nurse who administers compulsory treatment is equally morally culpable for his or her actions.

Despite the claim that neither a soldier or a nurse can morally defend their actions or inaction by stating that they were only following orders, it is readily apparent that the smooth running of both institutions relies on an ethos of obedience and deference to authority. Both the nurse and the soldier need to have faith that one's 'superiors' are acting morally. In relation to psychiatry, the nurse must have some faith in the psychiatrist, that he or she has the best interests of the patient at heart. The nurse must have faith in the "clinical judgement" of the psychiatrist. Just as an army is required to act in concert and with discipline, so too are health professionals. Indeed, courts have ruled on this matter and in a court ruling shared by Johnstone (1999, p.20) concerning a nurse who was dismissed by her employer for refusing to dialyse a terminally ill bilateral amputee, it was stated that "... it would be a virtual impossibility to administer a hospital if each nurse or member of the administration staff refused to carry out his or her duties based upon a personal private belief...". The duty and purpose of the nurse it would appear from this was to deliver prescribed treatment. Seedhouse (1997) has argued that medicine and nursing share a common purpose. It naturally follows, but is incorrect to assume, that they also shares a common conception of basic philosophical questions such as the meaning and implications of being human, and the experience distress.

A nurse who had spent two years working in an acute psychiatric unit following graduation and was contemplating changing careers, recently commented to me that she was yet to undertake the work that she was trained for. She was well aware of her legal responsibilities to contain and control people and intelligently follow medical instruction, but she perceived she had no freedom to provide nursing, or at least nursing beyond mere instrumental tasks. In this particular facility, medicine had authority over every aspect of the milieu, and a "doctor's order" was required for decisions, such as moving a patient from one part of the facility to another. Furthermore, this nurse had been inculcated during her formal education with a rhetoric of partnership, empowerment, recovery and nursing theory which hinted at the possibility of relating to and conceiving of people differently from the medical view. Her distress relating to this decision had a distinctly ethical dimension. She perceived that to challenge the orthodoxy of practice was to challenge the orthodoxy of the team and thus caste oneself as "the bad nurse", not a team player. Being a "team player" has modified the Nightingale ethos of "obedience" but carries a similar moral weight and sanctions in practice to ensure conformity.

Towards a nursing ethos

Nursing has long recognised the power and potential of nursing relationships for good and the centrality of the nurse-patient relationship in facilitating positive outcomes for people (Peplau, 1952). Peplau (1989a, p.271) has suggested that psychiatric nurses have a primary responsibility for nurturing and aiding psychiatric patients in their personal development and secondary responsibilities that include voluntary co-operative work with physicians who prescribe psychiatric treatments.

However, the primary responsibilities of nursing are seldom acknowledged in settings shaped by medical discourse. In many settings the secondary responsibilities of nursing have become the primary focus and the nurse-patient relationship is viewed simply as a vehicle to ensure compliance with medical treatment (Lakeman & Barker, 1999). The nurse described earlier was experiencing distress because in her view she was unable to engage in the primary roles of nursing which had been subjugated, invisibilised and illegitimised through a pervasive medical ethos. Even 'clinical supervision' which is considered something of a panacea for all that ails psychiatric nursing (Lakeman, 1999) had for her become a vehicle to discuss instrumental tasks such as risk assessment, ensuring compliance and maintaining control on the unit. Many nurses struggle to have recognised any contribution beyond assisting medicine, let alone a voice in ethical decision making.

The medical view of mental distress is but one of many which ought to have currency in shaping the provision of health care provision and defining roles. There is a seductiveness to the medical view of distress as illness, experience as symptom, and treatment with medicine. Indeed, nurses have been quick to avail themselves of opportunities, or push for the right to undertake medical procedures, prescribe drugs and undertake statutory tasks previously held by medicine. Barker (1999c) questions whether nurses may have found new roles but lost their way. Such developments do extend the nurse's sphere of influence, kudos, and may even fulfil a need within services, but without clarifying and valuing the primary role of nursing any claim to a unique perspective is quashed. As Barker (1999,b, p.109) notes "...we face a major ethical dilemma in choosing between our faith in biomedical explanations of ill-health, on the one hand, and listening to, and learning from, the people in our care... on the other".

Nurses need to take a lead in facilitating a new health care ethos, which values the contribution, unique perspectives, and moral competency of all people. Presently, the inclusion of nursing in decisions relating to compulsory treatment and nursing is often contingent on the 'good will' of medical practitioners and whilst in many instances this is forthcoming in others it is clearly not. Arguably the trend towards illuminating and promoting an "ethics of care" (Bradshaw, 1996; Gilligan, 1995; Kurtz & Wang, 1991) and methods such as sharing of stories and narratives (Benner, 1991; Olofsson, Gilje, Jacobsson, & Norberg, 1998) serves to promote an ethos of inclusion as well as drawing on nursing traditions. Whilst traditional approaches to ethical problems illuminate situations as problematic, relational and narrative ethics highlight traditional methods of decision making as problematic.

An ethics of care places human relationships at centre stage and any process of ethical decision making which systematically excludes patients, nurses and others who are intimately involved and affected by decisions is unethical. Research on ethical problems and how they are negotiated in acute and forensic psychiatric services continues to paint a picture of nurses being morally compromised. In a recent study, Lützén and Shreiber (1998, p.307) found that the "... nature and resolution of ethical decisions about patient care were contingent on whether or not the cultural or management milieu of the workplace was supportive of nursing practice, that is, a place in which personal and professional growth was encouraged or not". They (Lützén & Shreiber, 1998) suggest that nurses working in some contexts have limited choices because they work in a system which does not provide opportunities to challenge assumptions and work towards changing

non-therapeutic environments, without risking personal sanctions. The very nature of caring is compromised and the potential of nursing as a helping endeavour is lost.

Nursing has not yet adequately accommodated the reality of its instrumental functions into ethical theorising or practice. Should ethics be taught to nurses at all, if they are considered merely instrumental to medicine, if they have little choice but to do as they are ordered? Education may lead to moral distress and disenchantment. Peplau (1952) said of anxiety, that it presents a challenge to people to harness and channel the energy into productive problem solving. Moral distress may be functional and useful if channelled into solving the problems of institutionalised oppression, and hegemonic discourse which inhibit nurses from acting freely and creating a truly collaborative health care ethos. The creation of such an ethos is a moral imperative for ethical healthcare. Nurses must assert their right, and promote the rights of patients to be collaboratively involved in ethical decisions by virtue not only of their unique expertise and perspectives, but because of their shared humanity. Nurses cannot be mere tools and patients cannot be mere objects.

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