

THE NATURE, ORIGIN, AND VALIDITY
OF
ETHICS FOR NURSING ADMINISTRATORS

by

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(ABSTRACT)

The nature, origin and validity of ethics for nursing administrators were studied using a historical design with analytical and conceptual methodologies. This was done for the purpose of clarifying those issues for the practical matter of ethical decision making for nursing administrators. Research in that area has been limited.

An extensive analysis of 491 ethical articles, published from 1900-1989 and classified as personal, professional and administrative ethics; an analysis of the nursing codes of ethics and registration laws; trends in case and statute law; as well as conceptual literature and research provided the base for the facts, reasoned arguments, conclusions, interpretations and recommendations. Validity control features, (e.g., primary sources, multiple types of sources, and historical comparisons of trends) were used to minimize internal and external criticisms, as well as ensure integrity. Inter-rater reliability (90%) was ascertained to establish the consistency of the

classifications of the data for the sake of replication.

The results of this research supported the hypothesis that there is a distinctive nature to the ethics for nursing administrators, especially those employed in public organizations. This research also concluded that the ethic of the traditional staff nurse is inappropriate for nursing administrators. Less significant results and conclusions linked nursing administration with fresh ideas such as the public interest, public advocacy, public policy, constitutional competency, utilitarianism, and collective ethical decision making. A new model termed Collective Caring, was introduced as a more valid ethic. The Collective Caring Model has three major components (i.e., caring, cooperation and collectives) enhanced by utilitarianism. Collective Caring should be used to depersonalize the situation and integrate the values of the different collectives, as well as encourage utilitarianism, sharing, caring and cooperating for collective ethical decision making. Nursing administrators would be more critically aware of collective (e.g., public) values and more thoughtful about making ethical decisions. In addition, the effectiveness of the profession would be improved by clarifying and enhancing professional and collective relationships.

This dissertation is dedicated to those who remained close to me throughout this entire research process. This needs to include my husband, my son, my mother, my sister, my friends, and my cat. Success would not have been possible without everyone of them.

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TABLE OF CONTENTS

<u>Chapter</u>	<u>Page</u>
DEDICATION	v
ACKNOWLEDGEMENTS	vi
I. INTRODUCTION	1
The Problem and Setting	1
Professional Ethics	6
Ethics for Nursing Administrators	9
The Collective Caring Model	10
Definition of Terms	11
Scope and Limitations	13
Chapter Overview	15
II. A CENTURY OF CODES	18
Purpose and Benefits	19
Limitations	21
Enforcement	23
A Historical Perspective	26
The Codes' Content	33
Conclusion	44
III. A CENTURY OF CARING	45
Century Overview	46
Hospitals and Medicine	46

Health Care Policy	47
Nursing and Nursing Administration	49
Nursing Education and Ethics	50
Distinctions	53
Nursing	53
Nursing Administration	73
Public Administration	80
Ethical Concerns	88
Conclusion	106
IV. CURRENT CONCERNS	109
The Role of the Nursing Administrator	109
Conflicting or Confusing Responsibility and Accountability	115
Moral Behavior and Moral Development	117
Current Ethical Concerns	120
An Analysis of Published Current Ethical Concerns	122
Nursing Administration and Health Care Policy	125
The Public Advocate and the Public Interest	127
Conclusions and Interpretations	132
V. COLLECTIVE CARING	139
Summary	141
Caring	152

Caring and Cooperation	158
Caring about Collectives	162
Patient/Public Advocacy	163
Recommendations	169
Education	169
Action	170
Conclusion	171
REFERENCES	172
APPENDIX	
A A Suggested Code (1926)	186
B A Tentative Code (1940)	191
C A Code for Professional Nurses (1950)	201
D A Code for Professional Nurses (1960)	206
E A Code for Professional Nurses (1968)	210
F A Code For Professional Nurses (1976)	214
G A Code for Professional Nurses (1985)	219
H Oaths of Office	220

CHAPTER 1

Introduction

Ideals are like stars; you will not succeed in touching them with your hands. But like the seafaring man on the desert of waters, you choose them as your guides, and following them you will reach your destination.

Carl Schurz, 1829-1906

The Problem and Setting

At some point, the nature, origin, and validity of value sets need to be addressed if there is to be some agreement within a profession on the practical matters of ethical decision making. Problems arise when a professional is subject to the will of others (e.g., complex organizations as employers) in determining what tasks will be performed and what work priorities will be. This situation then involves roles or expectations about how an individual will

fill or perform a certain job. Role conceptions are actually value orientations which are used for ethical decision making.

Nursing administrators usually begin their nursing careers as staff nurses, socialized into the professional role by education, custom, tradition, rules, and ethical codes. The traditional ethic for a nurse has emphasized individual patient care. However, when one is promoted to a nursing administrator, previously used guidelines may conflict with the expectations of the new role. For example, the role of the nursing administrator is affected by the reality of fiscal constraints promoting cost containment which might be in direct conflict with the professional code encouraging high quality service. In addition, the job security of the nurse administrator can be seriously threatened if one tends to align more with the profession than with the hospital administration (Davis and Aroskar, 1978; Donnelly, Mengel and King, 1975).

Today's nursing administrator has an ethical responsibility to make judgments on three levels: first, as an individual who is responsible for oneself; second, as a nursing professional who is responsible for the quality care of individual patients, families or groups; and third, as an administrator, who is responsible for influencing health

care policies on a national, state, local, or institutional level. Few sources address the third level, or the complex interactions of the three levels. This research explores those deficient areas.

In a hospital system, the physician operates as a free entrepreneur and is accountable to the profession and the patient for his practice. The nurse is an employee of the institution and is accountable to the profession, to the patient and also to the institution. The hospital administration appoints and pays the Director of Nursing to manage the institution's nursing practice through a chain of administrative subordinates. Despite this arrangement, many physicians believe that medicine governs the practice of nursing and attempt to interfere in nursing affairs under the "Captain of the Ship" theory. That theory has been successfully challenged in the courts. In Darling v. Charleston Community Memorial Hospital (1965), the nurses, along with the physicians, were found negligent in a case involving a broken leg which turned gangrenous and had to be amputated. It was determined that the nurses' independent judgment could have made a difference in the outcome. In Muller v. Likoff (1973), the evidence showed that the negligence consisted of a nurse giving a medication inappropriately into the femoral nerve, causing harm to the

patient. These court cases held the nurses responsible for independent actions and judgments. The physician is no longer the "Captain of the Ship."

In addition to the complex relationship with the physician, the nurse administrator has a complex relationship with the hospital administration. It is generally assumed that nursing administrators are more aligned with the goals of management than with those of the labor force. However, is this assumption valid? If so, what supports or justifies this alignment? If that position is justified, why do staff nurses feel that nursing administrators are impotent (Godfrey, 1978)? Why do nurse administrators appear reluctant to become actively involved in policy making at local, state, and federal levels? This lack of involvement of nursing administrators in policy-making organizations has become so obvious that the National Commission on Nursing recommends that nurse administrators become qualified by experience and education to become part of the policy-making bodies of health care institutions.

In contrast, the American Medical Association (AMA) has been actively involved in policy issues. The AMA, for obvious economic reasons, has attempted to prevent the federal encroachment into health care. However, over the

years, federal concern and involvement in health care have increased as evidenced by legislation (e.g., Medicare, Medicaid, the Hill-Burton Bill, the Public Health Service Act, the Health Maintenance Organization Act, and the Comprehensive Health Manpower Training Act). Even with recent trends over the past few decades towards deinstitutionalizing psychiatric patients and privatizing the hospital industry, 31% of all hospitals were under government control in 1992 (Statistical Abstract of the United States, 1994).

Therefore, nursing administrators need to know the distinctions between public and private organizations (e.g., public organizations are subject to multiple external authorities and funding sources, have more internal bureaucracy and have more constraints on personnel decisions) and what those distinctions mean in regard to ethical decision making. Public organizations need to be concerned with and are accountable for a wider range of effects on society than private institutions (Lynn, 1984). As a result of increased accountability and more public scrutiny of public organizations, codes of conduct to assure fairness, responsiveness, accountability, and honesty are often developed. (Lynn, 1984; Rainey, Backoff and Levine, 1976).

Professional Ethics

The public's relationship with a profession is a unique relationship. The client depends on the professional's knowledge and must be able to trust the professional and the service rendered. Therefore, the profession is expected to take steps to ensure that the public's trust is well placed. One such step is the establishment and implementation of a code of ethical conduct. Professional ethics, as expressed in codes, generally reflect culturally defined goals and rules of the general public (Sward, 1976). Nursing codes have been discussed, developed and revised over the entire century, indicating that professional and societal values have evolved or developed.

The Nightingale pledge used since 1893 as a symbol of the nurse's public promise to society is quite brief. The American Nurse's Association's (ANA) first constitution in 1897 recognized a need for a code of ethics. That organization devised two codes ("A Suggested Code" in 1926 and "A Tentative Code" in 1940) before a Code for Nurses was adopted in 1950. That Code has been revised in 1956, 1960, 1968, 1976 and 1985. In 1956, only minor changes were made. In 1960, responsibilities for upholding standards, delegating activities and terms or conditions of employment were added. In 1968, all references to personal ethics were

eliminated. In 1976, revisions were made throughout the entire code and, although the 11 tenets from the 1976 version (see Appendix F) remained unchanged in the 1985 revision of the Code (see Appendix G), the interpretive statements, preamble and introduction were revised.

Arguments for developing, adopting, and revising the code throughout the century were based on the evolution of the role of the nurse. At the beginning of the century, the nurse was a subordinate to the physician and operated in the patient's home under the direction of the physician. By mid-century, the primary focus shifted to include nurses as hospital employees, following physicians' orders. More recent changes have recognized the expanded and independent role of the nurse.

That same change process is evident in statute and case law. State nurse practice acts have evolved from simple registration acts to more complex regulatory statutes broadening the scope of nursing practice. Older nurse practice acts were based on the idea that a nurse operated under a physician's license and followed physician's orders. Current nurse practice acts define the independent role of nursing and the legal accountability of the nurse to the patient. For example, in Lunsford v. Board of Nurse Examiners for the State of Texas (1984), a court upheld the

state board's decision to discipline a nurse for unprofessional conduct because she advised a patient to go to the next hospital (25 miles away) for emergency care when the physician told her to do so. On the way to the next hospital, the individual died of a heart attack. The court supported the state board's finding that the nurse should have made an independent assessment of the patient's condition. In discussing the nurse's legal duty to the individual, the court stated that the nurse-patient relationship stemmed from the privilege granted under the state licensing act and that duty was not dependent upon a third party (e.g., whether the man was a patient of the employing hospital or of the physician).

Court cases influence the role of the nurse by establishing interpretations and precedents that serve as future guides. Numerous recent court cases (e.g., Sermchief v. Gonzalez (1983); Gugino v. Howard Community Health Plan et al (1980); Muller v. Likoff (1973); Toth v. Community Hospital at Glen Cove (1968); and Whitney v. Day, M.D. and Hurley Hospital (1980)) indicate the trend toward an expanded nursing role and the independence of the nursing profession.

Ethics for Nursing Administrators

The trends discussed above further indicate that the role of the nurse administrator is changing and the ethical base for decisions associated with that role is also changing. In addition, the value set for the individual professional nurse is not an adequate base for ethical decision making as a nurse administrator. Nurses need to know the origin, nature and validity of ethics for nursing and nursing administration. That knowledge needs to be part of the basic education for nurses. To wait until the nurse is promoted to the administrative level invokes the Peter Principle. The nurse administrator without administrative values can not be expected to make informed ethical choices.

The focus of this dissertation is on the nature, origin and validity of ethics for nursing administrators. The study combines historical, analytical, and conceptual perspectives. The intent of this approach is to encourage the development of nursing administrators who are more critically aware of their own values and more thoughtful about the ethical decisions they are inevitably called upon to make. Such thoughtfulness should increase the nurse administrator's self-confidence and this, in turn, should have a positive effect upon professional performance. Further, this deeper professional self-awareness should

contribute to more clearly defined relationships within the health care system. Finally, the results of this study will be helpful in the important work of developing an appropriate code and ethical framework for nursing administrators.

Although there has been an increasing volume of research and conceptual literature on the subject of nursing ethics, less has been written about ethics and nursing administration, and research has been limited in that area. This is particularly true of nursing administration in public organizations.

The Collective Caring Model

This dissertation argues that the current nature of ethics for nurses is invalid for nursing administrators and especially for those employed in public organizations. An administrator cannot focus on being an individual patient advocate. The focus needs to be on collective caring for a large group of patients and the public. The nurse administrator needs to be a public advocate. This does not mean the administrator disregards one's commitment to the values and principles of the nursing profession or one's own personal values. Instead, an administrator needs to reexamine personal and professional values and use that

knowledge to become involved in policy making and political groups.

The value sets of all participants can be shared in the Collective Caring Model. The nurse administrator needs to represent the nursing profession as a collective, and actively share the values of the profession with other administrators and professionals in policy-making bodies in the health care arena. Nurse administrators also need to represent and share the public's interest and public values about health care in policy-making arenas. Nurse administrators need to espouse patient advocacy, patient autonomy, and patient well-being on a collective level and convert their caring into public advocacy, public autonomy, and public well-being.

Definition of Terms

Before getting into the substance of this dissertation, several key terms must be explained or defined. "Nursing Administrators" refers to nursing leaders (e.g., supervisors, assistant directors and directors of nursing) who are concerned with collectives of patients and whose jobs involve discretionary judgment rather than the routine execution of procedures. Nursing administrators are responsible for the provision of nursing care to recipients

served by organized nursing services (e.g., departments, agencies etc.). Because the scope and responsibilities for nursing administrators are expanding across all health care settings, ANA has revised Standards for Organized Nursing Services (1988). These standards apply to all settings in which nursing services are delivered. The document distinguishes between nurse executives and nurse managers. However, for the purpose of this study, "nursing administrator" incorporates both the nurse executive and the nurse manager. Both are concerned with collectives of staff and patients, consistent with the focus here.

Standard VII of ANA's Standards of Organized Nursing Services refers to ethics. That document states that nursing service policies to guide ethical decision making for the nurse are to be based on the ANA Code for Nurses (1985). That code is a professional code which addresses professional ethics. Throughout this dissertation, "professional ethics" refers to broad systems of moral principles involving the distinctive choices and actions of the named profession which are professionally sanctioned and implemented (e.g., "administrative ethics", "medical ethics" and "nursing ethics").

The word "ethics" refers to a broad system of moral principles that includes both professional and personal

(moral) rules of right and wrong choices or action. Because ethical discussions usually include personal values, attitudes and beliefs, the words ethics and morals will be used interchangeably. "Moral" usually refers to a more personal conformity to the rules of right, good or virtuous behavior than ethics. But that will not be the case here. Here, the word "morality" refers to the conformity to norms of right, moral or virtuous conduct. "Virtue" refers to a good or admirable quality. Major sections of this dissertation look at values. "Values" refer to beliefs, principles, states of being, or qualities that a given person or group of persons deem desirable.

In addition to the above terms, major concepts (e.g., the public interest, public organizations as well as accountability and responsibility) will be delineated in appropriate places in this dissertation. Further, a new model, "Collective Caring," will be defined and discussed in chapter 5.

Scope and Limitations

Many extremely important ethical problems associated with nursing are not included because they pertain more to the individual professional nurse's choices and actions. Despite their inherent importance, many of these problems do

not pertain to nursing administrators, as such. Other problems affect nursing administrators differently from the way they affect the nursing practitioner.

A historical and analytical perspective is used for this study in an attempt to establish relationships and meanings of past trends which influence the current status of ethics for nursing administrators.

Validity control features, (e.g., primary sources, multiple types of sources, and historical comparisons of trends) were used to minimize internal and external criticisms, as well as ensure integrity. A graphic scale using short descriptive phrases derived from the definitions in this study was used to classify the data as personal, professional or administrative ethics. A inter-rater reliability (.90) was ascertained for the sake of consistency and replication. In addition, a careful review in chapter 3 of how four articles on the same ethical concern (abortion) in the same journal, were classified differently, should ensure reliability and replication of this research.

This study is limited to the ethics of American nursing administrators. From one country to another, nursing differs in fundamental respects not only in regard to law and policy, but also to tradition and beliefs. These

differences can be related to what Rohr (1978) refers to as regime values. Regime values reflect salient values of a particular society and can be found in a variety of sources.

Chapter Overview

This chapter introduces the focus of this research: the nature, origin and validity of ethics for nursing administrators. The purpose is to describe the current concern or nature of the problem for nursing administrators. The traditional nursing ethic emphasizes individual patient care. This is not a valid perspective for nursing administrators to use for ethical decision making involving collectives of staff and patients. Before researching the problem further, definitions of terms as well as the scope and limitations of the study were made explicit.

Chapter 2 explores the purpose, limitations and enforceability of professional codes in general and the Code for Nurses in particular. The origin of the Code and its revisions are discussed in detail. A content analysis combined with a historical perspective of the various nursing codes throughout the twentieth century is presented to reveal consistencies and changes. The unique values of the profession are evident from that analysis. Those values are the basic orientation of nursing ethics.

The current Code is based on the premise that the nurse is an autonomous professional. The nurse has not always been autonomous. Chapter 3 will provide a historical perspective of nursing, statute and case law, as well as a historical narrative of health care policy, and the ethical themes in nursing periodicals during the twentieth century. These historical analyses will indicate the trends leading to autonomy and the freedom to make independent ethical decisions. A distinction is made between medical and nursing ethics as well as professional and administrative ethics.

The current nature of ethics for nursing administrators is explored further in Chapter 4. Current employment settings in public organizations and the concept of the public interest are discussed. A fresh perspective of nurse administrators as public administrators governing policy in health care setting is offered.

In the last chapter, a new model termed "Collective Caring" is presented. That model focuses on collectives: shared collective values, collective advocacy, and responsibility and accountability to collectives. Recommendations are made about how ethics for nursing administrators can be developed further and justified. That justification should affect professional performance

positively. It is hoped that a professional code and an ethical framework for nursing administrators will be developed in the near future.

CHAPTER 2

A Century of Codes

To begin to understand the origin, nature and validity of ethics for nursing administrators, an examination of the early collective ideals of the profession is in order. This chapter examines the historical development of codes for nurses and other pertinent historical literature. Its purpose is to analyze the origin and revisions of the nursing codes in order to discover the implicit and explicit ethical values that undergird them.

It is generally accepted that the statements in the professional codes represent a consensus of professional nurses and, therefore, a thorough analysis of the codes will reveal the collective values of the profession. In addition, a code is usually derived from broader, more fundamental beliefs which will also become more evident.

This chapter will cover the purposes, limitations and enforcement of professional codes in general and the Code for Nurses in particular. The results of an in-depth analysis of the various revisions of the Code conducted by the author of this dissertation will be combined with a historical perspective of the evolution of the Codes.

Purposes and Benefits

The purpose of a professional code can be subdivided into the purposes benefiting: (1) the public; (2) the profession; (3) the practitioner; and (4) the patient or client. As a collective, a profession has a distinctive relationship with society. Society grants a high degree of autonomy to a profession and in return professionals are expected to act responsibly to protect the public from unethical and incompetent practitioners. A profession is expected to police itself. A professional code is an important means toward meeting the challenge of self-regulation. Members of the profession are expected to comply with the code and the profession is expected to enforce the code. Thus, a code functions as a tool of the profession's accountability to society. Such a code functions as an oath or promise made by the profession collectively to the public that minimal standards will be upheld by individual professional practitioners. A code informs society of what it can expect from the profession and provides evidence of a profession's values, priorities and aspirations (Sward, 1975). By setting and enforcing standards, the code also upgrades the quality of health care available to the public.

A code serves not only the public, but the profession, the individual practitioner and the patient or client as well. As previously stated, by establishing minimal standards, the profession is continually upgraded. As a tool, it is used to assist with the governance of nursing through attempts to influence legal regulations (e.g., licensure), institutional accreditation, educational content, and enforcement provisions. The profession also uses a code as an educational tool to assist with clarifying the differences between personal and professional values.

With a code, individual practitioners can also be protected. A professional code can provide guidance and direction for professional conduct and ethical decision making, as well as justify that conduct and ethical decision making. As an educational tool for the individual practitioner, a code can: (1) clarify differences between professional and personal values; (2) socialize new practitioners into the profession; (3) clarify responsibility and accountability; and (4) assist with upgrading individual practice through adherence to minimal standards, self-discipline and the evaluation of practice.

Codes also benefit individual patients. The rights of individual patients have been stressed in codes since the

Nazi atrocities in World War II. Improved care, a purpose previously mentioned, also benefits the patient. Codes protect the individual patient who is vulnerable because of illness or injury and must depend on the professional's specific knowledge and skills (Benjamin and Curtis, 1981). The patient is protected from unethical and incompetent practitioners.

In sum, codes have numerous purposes. Those purposes benefit the public, the professional, the practitioner and the patient or client. However, where there are benefits there are also limitations.

Limitations

There are limitations to professional codes for the public, the profession, the practitioner and the patient or client. Codes may reflect the vested interests of the profession which could mask deep conflicts between the public and the profession (Bandman and Bandman, 1985). Professions may be looking for benefits in the form of higher salary, greater prestige or other benefits which society is not willing to grant. The public needs to be careful that long term benefits of professional conduct out-weigh the potential risk of self-serving tendencies in many professional codes (Rohr, 1982).

A professional code does not suffice as the only guidance needed by a profession to assure ethical practice. Stenberg (1979) examined four concepts as philosophical bases for nursing ethics: code, contract, context and covenant. She found strengths and weaknesses in all the concepts. In her study of codes she concluded that the Code for Nurses is insufficient as a philosophic base for nursing ethics. Not all professions see a need for a code. Other professions feel that a traditional oath serves as a code. For example, the National Council of the American Society for Public Administration (ASPA) in 1981 adopted a statement of principles in lieu of a code of ethics. In the wake of that decision, Chandler (1983) analyzed the arguments for and against a code for ASPA. The arguments against a code came from concern about practicality, procedure and administrative theory, and the arguments for a code came from the need for objectivism, community and courage. Other authors (e.g., Rohr, 1982) have shown that public administrators have a statutory mandate to take an oath to uphold the Constitution. Some see no need for further oaths or codes (Chandler, 1983). Nevertheless, ASPA adopted a code of ethics in 1985.

Numerous authors (e.g., Benjamin & Curtis, 1981; Muyskens, 1982; Silva, 1974) address the vagueness and

generality of codes which make their applicability to specific situations questionable. For example, Silva (1974) points out that the Code does not clarify how the nurse is to resolve conflicts between professional and personal values or changing values. Another author (Sward, 1973) argues that ethical decisions are to be based on the professional code and not one's personal code. She bases that stand on the premise that the right to make ethical decisions comes from the patient (or the collective public). The patient turns over to the profession (not the individual) the task of making ethical decisions. These concerns have led to the listing of another limitation of codes: individual interpretations of the code which may differ (Benjamin & Curtis, 1981; Silva, 1974). This may create serious concern for the individual client or patient.

In sum, there are limitations to different kinds of codes (e.g., brief, vague, or a traditional oath) as well as cautions about the general use of professional codes and the practical use of codes to the individual practitioners. Although not considered a limitation, enforceability may certainly be seen as a weakness or problem (Chandler, 1983).

Enforcement

Sward (1975) and ANA (1980) both presented good

descriptions of the differences between ethical standards and legal standards. The Code for Nurses establishes the ethical standard for nursing and the nurse practice acts of each state set the legal standard. Ethical and legal standards differ in their goals, establishment, enforcement, and sanctions for violations. The goal for setting legal standards is to ensure a minimal level of competence, while the goal for setting ethical standards is to promote both moral and high quality practice. Legal standards are established by legislative, executive or judicial action and ethical standards are established by professional associations. Legal standards are enforced by an arm of state government (e.g., the state board of nursing) and ethical standards are enforced by a body of the professional association (e.g., a council on ethical practice). The sanctions for violations of legal standards relate to licensure and the sanctions for violations of ethical standards relate to membership in the professional association.

ANA has provided written guidance for implementing and enforcing the Code (ANA, 1976; ANA, 1980). Further guidance for implementing and enforcing the Code in local situations may be obtained from the professional state organizations (e.g., New York State Nurses' Association's Council on

Ethical Practice). Each state constituency of the ANA has the authority and responsibility for handling alleged violations of the Code by their members. Code violations are reported through mechanisms in employment settings. State nurses' associations provide processes for further discipline and appeals. Disposition of alleged violations may include, but not necessarily be limited to, dismissal of the charges, reprimand, censure, suspension or expulsion from the state nurses' association. Referrals may also be made to the appropriate legal authorities if the alleged violation appears to be of a criminal nature.

Silva (1984) appraised the Code for Nurses in terms of purposes, specificity, inclusiveness, and enforceability. The results of her study showed reasons for supporting the Code in regard to the concepts studied. However, she concluded that there was limited data available about sanctions for violations of the code. Silva alluded to an abstract of Mooney's (1980) research on the Code for Nurses. As part of that research, Mooney reported that 42 state nurses' associations had no reported violations of the Code and five stated that action on allegations of violations of the code had occurred. Mooney concluded that there were few instances of the professional body applying sanctions for code violations and the code needed provisions for sanctions

in order to be considered a complete code according to the criteria used for her study.

In 1979, the ANA Committee on Ethics compiled the information it received from various state nurses associations regarding activities involving organizational structure for ethical concerns, ethical dilemmas, and the use of the Code. Twenty-eight state nurses' associations responded. Only one state reported that a hearing for an alleged violation was held in the previous two years. In addition, one alleged violation had been referred to the State Board of Nursing. Another state association had been advised by legal counsel to stop the hearing process because of the possibility of slander. Six states reported that procedures had been developed for handling violations of the Code. Other states requested guidance from the ANA for developing such procedures.

A Historical Perspective

Some authors (e.g., Silva, 1984 & Sward, 1978) offered brief historical perspectives of the development of the Code for Nurses as introductions to further discussion. However, a thorough, systematic collection and critical evaluation of data about the development of the Code was not found. A thorough historical perspective would be useful to

illuminate the previous ethical concerns and enhance the understanding of the current Code. The following section of this paper is the results of such historical research conducted by this author.

Nursing, newly organized at the turn of the twentieth century, was striving for a basic standard of performance and education. The Nurses' Associated Alumnae of the United States (known as the American Nurses' Association after 1911) was the official nurses' organization. The constitution and bylaws of that organization were published with the report of the Seventh Annual Convention in the American Journal of Nursing (AJN) in May 1904. One objective of the organization, mentioned in their constitution, was to promote ethical standards in all relations of the nursing profession.

Although a code of ethics provides a means of demonstrating a commitment to promote ethical standards, the ANA did not adopt one until 1950. The ANA's first priorities as a fairly new organization were to organize nurses in the different states and to encourage registration through licensure as a means to promote high ethical standards. In 1920 licensing laws were secured in 45 states, Hawaii and the District of Columbia (Gerds, 1960).

Because having a code was considered to be a

characteristic of a profession and a tool for self-discipline, work on a code began to receive attention at the beginning of the century, even though having one did not seem as important as organizing or registering.

Discussion began about the content of a code. Disagreements centered on whether the code should: (1) contain specific rules or general principles; (2) be a professional code or a moral code; (3) emphasize protection of the profession or of the public; and (4) be enforced or merely pronounced (Editorial, AJN, August 1926; Limbert, December 1932).

"A Suggested Code" was read and discussed at the ANA meeting in May 1926 and printed in the AJN in August 1926 (see Appendix A). "The Suggested Code" was intended to be presented to the ANA membership for support and refinement at the biennial meetings. That code was divided into relationships of the nurse: (1) to the patient; (2) to the medical profession; (3) to the allied professions; (4) to other nurses; and (5) to the nursing profession. It was a mix of personal and professional ethics stressing accountability to the physician who was "legally and professionally responsible for the medical and surgical treatment of the sick" ("A Suggested Code," AJN, August 1926). There was no mention of administrative duties or functions of the nurse. The nurse was referred to as a

"public servant" with many-sided relationships and a "larger loyalty" to the community.

After "The Suggested Code" was published, three discussions about the code were printed in AJN in 1928. In the "Ethical Problems" column, Dr. Manwaring, a physician, asked if nursing was too concerned with ethics and education away from the bedside, and suggested more personal examples in the lesson of selfless service. He thought nursing had gone too far without conferring with physicians and hospital administrators. Functions of professional codes identified in a contemporary book by Dr. Landis were listed in the 28th volume of AJN as: (1) protection of the public and the profession; (2) professional discipline and control; and (3) provision of specific rules for specific situations (e.g., rules for conflicts in professional relationships). In another issue of the same volume, the ANA offered some thoughts about codes and urged the component organizations of ANA to use them as incentives for further discussions.

In 1932, Paul M. Limbert, Ph. D., examined the values and limitations of professional codes of ethics and analyzed ANA's suggested code. He pointed out omissions (e.g., the duties of supervisors and enforcement procedures). Limbert saw the values of professional codes as means to: (1) educate and orient nurses; (2) discipline nurses; (3)

protect the public from incompetent practitioners; and (4) protect the profession by advancing the economic and educational interests of the profession as well as by preventing demands for excessive hours or unjust criticism by physicians. It is interesting that these omissions had more administrative and professional ethics than the suggested code, which was a mix of personal and professional ethics.

In 1935, a report of the ANA Committee on Ethical Standards summarized the committee's activities in regard to a code of ethics. Neither ethical principles nor a code had been developed further than the 1926 suggested code. The inability of the committee to carry out its purpose of developing a code was blamed on: (1) lack of time; (2) difficulty in reconciling opinions through correspondence; (3) lack of real knowledge about ethics; and (4) divergent views of the different nursing specialties about ethical problems. To assist further, a Working Committee and an Advisory Committee on Ethical Standards were appointed. Those committees began to work on formulating some general principles to serve as guides. Because of the time needed to complete that task and the urgency felt for a code, "A Tentative Code For The Nursing Profession" was developed and published in AJN in September 1940 (see Appendix B).

The statements in "A Tentative Code" recognized nursing as a profession, and expressed in a general way the responsibility of the nurse to herself, to patients, to other members of the profession, to the profession at large, to members of allied professions, and to the public. It was again a mix of personal and professional ethics. No mention was made of any supervisory or administrative ethics. Again, the nurse was accountable to the physician. However, the administrative officers of the employing agency and the local medical society were mentioned as sources to be notified if unethical or illegal conduct was noted. Ethical responsibilities to "administrative officers and other personnel in the institution or agency," as well as responsibilities to the public for public health, were added.

The next decade and the war years served to improve the image of the profession of nursing and improve standards of care. More graduate nurses were employed in institutions and nurses had more independent functions as health care providers. However, a code for nurses had not been developed.

The long-term objections to formulating a comprehensive and authoritative code of ethics continued, because the 1940 Tentative Code did not have group support. Education about

the value of a code was also needed, according to Charlotte C. Skooglund, Chairman of ANA's Special Committee on Ethical Standards (1947). In 1949, the ANA Committee on Ethical Standards, in an attempt to acquire group acceptance and commitment, circulated a checklist questionnaire to all state associations, the five existing national nursing organizations, the American Hospital Association and the American Medical Association. That committee tabulated and studied returns representing the participation of 4,789 people. Those responses were used to formulate "A Code for Professional Nurses." That code was accepted in 1950 by ANA as the official Code for Professional Nurses (see Appendix C). ANA was the first national nursing organization in the world to adopt a code of ethics. The International Code of Nursing Ethics, adopted by the International Council of Nurses three years later, was based on the ANA Code (Sward, 1975). More recently, that same organization adopted the ANA Code as The International Code of Nursing Ethics.

The contents of the first ANA Code and its subsequent revisions are quite relevant to the study of the origin, nature and validity of ethics for nursing administrators. Therefore, a content analysis of the Code was done by this author. The results of that analysis are combined here with a developmental or historical perspective of the various

revisions of the codes through the most recent revision in 1985.

The Codes' Content

The 1950 ANA Code for Professional Nurses was brief, as requested by the membership, with 17 tenets composed of general principles. The contents of the tenets of that code and the revised codes throughout the century were analyzed and categorized by this author as pertaining to either personal, professional or administrative ethics. The content of the 1950 tenets numbered 10, 13, 14 and 17 was classified as personal ethics. The remaining 13 tenets were considered professional ethics. No mention was made in the 1950 Code of supervisory or administrative ethics. That code recognized that "service to mankind" was the primary function of the nurse. It also mentioned that the nurse subscribed to the democratic values to which our country is committed. Although two tenets (7 and 8) referred to relationships with the physician and other professionals in regard to unethical conduct and practices, less responsibility and accountability to the physician was discussed in the 1950 Code than in the 1926 or 1940 "codes" and more responsibility to patients was stressed. In addition, tenet number 16 discussed the nurse's

responsibility to promote efforts to meet the health needs of the public.

The Ethics Committee printed a series of articles in 1952 and 1953 in AJN explaining and interpreting the Code in detail. There was a mention of nursing administration in the interpretation of the 13th tenet. The 13th tenet addressed standards of personal ethics in the nurse's private life. The profession welcomed "good" women. The assumption was that the "good" person made a "good" nurse administrator. "The good nurse administrator fully recognizes that employees are not merely means to an end _____."

Over the next few years after the 1950 adoption of the code, numerous questions came up about nursing, and numerous violations of tenet 11 addressing nursing testimonials in advertising were reported. Therefore, ANA's Committee on Ethical Standards studied the issue and proposed and recommended a revision. The revision to the 11th tenet, designed to give more specific guidance in the area of advertising products and services, was unanimously approved in May 1956 (Beck, 1956). Also in 1956, the title was changed from A Code for Professional Nurses to The Code for Professional Nurses. A Code suggests more than one code, while The Code suggest the supreme authority of the one and

only code.

During the ANA 1958 convention, delegates directed that the Code should incorporate the concept that nurses have an ethical and professional duty to maintain high economic and professional standards in order to preserve nursing and quality nursing care for society. Toward that goal and the goal to eliminate overlapping and repetition with other documents, each statement of the Code was reviewed and a new code was drafted in 1960 (see Appendix D).

Functions of nurses were deleted in the 1960 revision because the profession had prepared statements of functions, standards and qualifications, as well as a definition of nursing practice since the 1950 Code was written. Therefore, the preamble was shortened. The purpose of the proposed code was to provide standards for professional conduct and professional relationships (ANA, 1960). The 1960 tenets 1 through 5 relate to the responsibilities of the nurse to society, tenets 6 through 14 relate to the responsibilities of the nurse to the profession and 15 through 17 relate to the responsibilities of the nurse to allied workers. The contents of the tenets were rearranged. The concepts of numbers 7, 8, and 12 of the 1950 code, referring to relationships with allied workers, were reworded for clarity and renumbered 16 and 17. The 1960

Code changed the emphasis from sustaining confidence in the physician to the obligation of protecting the patient from incompetent, unethical or illegal practices. This wording also indicated a more independent and personally responsible role for the nurse (ANA, 1960). Tenets 15, 16, and 17 of the 1950 Code pertaining to citizenship were combined into tenets 5 and 9 in 1960. The committee decided to delete specific duties of citizenship and substitute more general principles which would be more useful for interpreting the Code. The wording of the 1960 tenet 9 also reflects the independent role of the nurse.

Tenet number 12 of the 1960 Code, stating that the nurse adheres to standards of personal ethics which reflect credit on the profession, replaces tenets number 13 in 1950, referring to personal ethics and number 14 in 1950, referring to community norms. It was felt that the 1950 tenet 14 could be in opposition to other national ANA goals (ANA, 1960). At the 1946 biennial convention, ANA decided to admit Negro nurses to equal membership. However, there were 10 states remaining which did not admit Negro nurses to the state organizations. A need was seen at that time to allow the state associations to conform to local norms (ANA, 1947). However, as time went on, ANA became stronger about its stand for the integration of Negro nurses.

Tenets numbered 3 and 6 in 1950 were deleted because the committee felt that they were more suitable for use as interpretive or explanatory statements than as specific provisions of the Code. Other tenets (e.g., tenets 2, 3, 4, 8, 13, and 14) of the 1960 Code were reworded to provide clarity.

The 1960 Code provided more detail regarding areas of accountability. The new tenets numbered 6, 7, 10, and 11 stress more active participation as a professional in collectives or groups to obtain and maintain higher standards for the profession. Tenets 3, 5, 11, 15 and 17 stress the nurse's responsibility to protect the public or act as an advocate for the public. An administrative statement is included for the first time in tenet number 15 about the ethics of delegating tasks as a means of protecting the public. Personal ethics were still expressed in tenets 3, 5 and 12. Thus, this Code was a mix of personal, professional and administrative ethics.

In the years between 1960 and 1968, ANA dispensed the Code to all nurses and focused on implementing the Code. New provisions on disciplinary action for violation of the Code were approved by ANA bylaws. "Suggested Guidelines for Handling Alleged Violations of the Code for Professional Nurses" was published and distributed to the state

organizations (ANA, 1964). These guidelines suggested procedures for the state associations for handling violations of the Code. Emphasis was on the positive aspects of familiarizing the nurse with nursing standards, principles, and policies.

In 1966, the Committee on Ethical Standards recommended that the Code remain fairly stable. The Committee felt that current practice would be reflected in the Code's interpretation (ANA, 1966). Toward the goal of creating a more stable code, another revision was designed and presented at the 1968 ANA convention by the Committee on Ethical, Legal and Professional Standards which was created in 1966 by bylaws changes.

In 1968, the title was shortened to delete the word "professional." The code should be applicable to all practitioners of nursing (ANA, 1968). The first tenet of the 1960 code, addressing the nurse's responsibility to conserve life, alleviate suffering and promote health, was deleted because the concept was basic and appeared in the preamble (ANA, 1968). Tenets 8 and 9 of the 1960 Code are combined to form tenet number 3 of the 1968 Code. The committee stated that the revision clarifies the responsibility of the individual nurse to maintain competence and to be responsible for individual actions and

judgments. Tenets numbered 2, 4, 17, 15, 7, and 13 of the 1960 Code were reworded to form tenets numbered 1, 2, 4, 5, 8, and 10 respectively in the 1968 code. The committee's revisions were designed to clarify the concepts and broaden their applicability. Only concepts relating to the nurse as a professional practitioner were included; references to the duties of citizenship were omitted. A new tenet (i.e., number 6) was added to clarify the role of the nurse practitioner practicing in research settings. Tenet number 3 of the 1960 Code was included in the preamble in 1968. Five tenets (i.e., 6, 11, 12, 14, and 16) were deleted in 1968 because the concepts were incorporated in other tenets or the concepts were not appropriate (ANA, 1968).

In 1968, after almost two decades of functioning under an official code for nurses, all references to personal ethics were deleted. The ANA membership felt that references to a nurse's personal conduct had no place in a code directed toward professional practice and professional conduct. In addition, suggested guidelines for handling violations of the Code make it clear that enforcement refers to activities of the profession to deal with illegal or unethical professional behavior (ANA, 1964). Enforcement of personal behavior is not possible by a professional organization.

The 1968 Code was condensed to 10 tenets relating only to

professional ethics (see Appendix E). Only one statement (number 5) made some reference to an administrative function: "The nurse uses individual competence as a criterion in accepting delegated responsibilities and assigning nursing activities to others." Concern for the patient's safety was seen as the primary consideration in accepting and delegating duties. More emphasis was placed on the nurse's accountability to the patient and patients' rights. This Code clearly places the nurse in the position of patient advocate and stresses the nurse's responsibility for her own actions. No mention is made of accountability to physicians or employers. This represents the trend recognizing the independent, cognitive actions of the nurse. The 1968 and subsequent codes were usually published with interpretive statements for ready reference.

The 1976 revised Code contained 11 instead of 10 tenets. The added tenet (i.e., 4) stated "The nurse assumes responsibility and accountability for individual nursing judgments and actions." This tenet emphasized the independent functioning of the nurse. Although some of the wording of the tenets was changed, few significant changes were made in the tenets themselves (see Appendix F). Tenets numbered 3, 4, 9, 8, 7, 6, and 5 of the 1968 Code were revised and were numbered 5, 3, 11, 9, 8, 7, and 6

respectfully, of the 1976 Code. Some of the interpretive statements were condensed and some were expanded to enhance understanding and reference to specific issues. The word "patient" was changed to the word "client" throughout the tenets and interpretive statements, indicating a trend toward an emphasis on health rather than on illness. The introduction was expanded to include a statement underlining the nurse's accountability to the client and de-emphasizing prescriptive responsibilities to physicians or employers. For the first time, the introduction contained a statement about violations of the Code and the law. A preamble was also added stating the assumptions and intent of the Code.

Tenets 3, 10 and 11 included references to the public, emphasizing expanded accountability to act, not only as patient advocates, but public advocates, as well. The interpretive statement of number 8 also stressed the nurse's responsibility to the public to admit only competent nurses to the profession and to maintain optimal standards. No references were made to personal ethics. Ten of the 11 tenets referred to professional ethics. Tenet number 6 referred to the administrative functions of seeking consultation, accepting responsibilities and delegating nursing activities to others. The changes in the 1976 Code represented the expanded and independent role of the nurse

as well as the expanded responsibilities and accountabilities of the nurse to the patient and to the public.

The Code was revised most recently in 1985 (see Appendix G). The 11 tenets remain the same, but the preamble, introduction and interpretive statements have been revised. The changes emphasize the patient's rights and the nurse's obligations to the patient and the public, as opposed to the physician or employer.

The preamble emphasizes professional values in regard to the patient's right to self-determination and the nurse's obligation to act as the patient's advocate. The preamble also lists for the first time the universal moral principle of respect for persons, and the principles (e.g., autonomy, beneficence, nonfeasance, veracity, confidentiality, fidelity, and justice) which, along with consequential considerations, act as bases for ethical decision-making by nurses.

The introduction addresses the purpose of the Code as:

- (1) an indication that the profession has accepted the responsibility and trust invested in the profession by society to function autonomously;
- (2) a means of professional self-discipline;
- and (3) a collective expression of nursing conscience and philosophy.

In sum, this in-depth content analysis of the revisions of the Code over the years discloses several trends. There has been a shift in responsibility and accountability from the physicians (1940) and the employer (1940) to the patient (1950, and thereafter) and the public (1960, and thereafter). Each progressive revision encouraged more patient advocacy and public advocacy. Each version also reflected progressive professional autonomy. Early codes stressed personal ethics and later codes stressed professional ethics. One tenet referring to administrative ethics in regard to the acceptance of responsibility and the delegation of nursing activities appeared in 1960 and has continued throughout the subsequent revisions. Administrative implementation (1968) and enforcement (1976 and 1985) of the Code have also been recent administrative additions to the Code.

In addition to the changes and trends the analysis disclosed, there have been ethical issues that have remained the same. The basic content of six tenets has existed throughout the 1950 Code and the subsequent revisions, enduring the test of time. They are ethical guidelines regarding: (1) maintaining professional competence; (2) maintaining confidentiality; (3) respecting human dignity without prejudice; (4) practicing ethically in regard to

advertisement; (5) protecting the patients and the public against unethical or illegal practices; and (6) promoting efforts to meet the health needs of the public. Therefore, it can be assumed that these six are lasting and enduring values that are collectively expressed by the caring profession of nursing.

Conclusion

This chapter has studied the purpose, limitations and development of professional codes. The nursing profession believes that a code of ethics is quite useful, as evidenced by the efforts to develop and revise the Code. A content analysis combined with a historical perspective of the codes throughout the century revealed consistencies and changes. These consistencies and changes indicate the unique values of the profession.

The current Code is based on the premise that the nurse is an autonomous professional in the role of patient advocate to ensure patient autonomy. The nurse has not always been in an autonomous role. In the next chapter, a historical perspective of nursing over the century will indicate the trends leading to autonomy and the freedom to make independent ethical decisions.

CHAPTER 3

A Century of Caring

The role of the nursing administrator has evolved over the century due to various interrelated aspects of the health care system and the environment. The purpose of this chapter is to present the argument that the role of the nursing administrator is unique and quite different from the nursing practitioner or the physician. Because nursing administration is distinctive, so are the ethics for nursing administrators, especially those employed as public administrators in public organizations.

Chapter 3 will provide a historical perspective of hospitals and medicine, nursing statute and case law, health care policy, nursing administration and nursing ethics throughout the twentieth century. These historical trends will provide a basis for understanding how the profession of nursing became autonomous and how nursing administration evolved. That basis is necessary for further understanding the distinctive origin, nature and validity of ethics for nursing administrators.

Century Overview

Hospitals and Medicine

The scientific, technological and societal trends of the twentieth century have had a significant effect on nursing and nursing administration. Life expectancy has been prolonged and the standard of living has been improved. The nature of disease has changed dramatically. At the beginning of the century most patients had communicable diseases. Today, most patients have cancer or heart disease. In addition, patients themselves have changed, from passive acceptance of medical opinions to greater self-direction and decision making (Dolan, Fitzpatrick & Herrmann, 1983).

Scientific and technological advances also helped change the image of hospitals from places for the poor and dying to institutions where patients, including those of the middle and upper classes, go to receive treatment and regain health (Bullough & Bullough, 1978). Federal funding has contributed towards the increase in numbers and the size of hospitals over the century. This increase in turn has resulted in a more positive image of hospitals.

After WW II, physicians began to appear more frequently in hospitals. Hospitals were then considered workplaces for

the physician, where physicians and hospital administrators held the principal positions of power. The roles and functions of nurses were heavily influenced by what those physicians and hospital administrators encouraged and permitted nurses to do. (Deloughery, 1977).

The health care system has evolved around a private enterprise orientation with the physician as entrepreneur and other workers perceived as subservient. The medical model with the physician as entrepreneur led to an illness-oriented system of services. There is an ethic of control over death through scientific or technological means and an attitude of lifesaving at all costs (Benoliel & Packard, 1986).

Health Care Policy

The current health care system and health care policies show an imbalance in the priorities of care and cure. Although care is espoused as important, cure is the goal around which the health care system is organized (Dye, 1987). Cure focuses on the diagnosis and treatment of disease. Care is concerned with the well-being of the person. Cure is more objective, whereas care is more subjective. Cure has its origin in science, whereas care has its origin in respect for persons, and human compassion

(Benoliel & Packard, 1986).

Throughout the century, compulsory health insurance or some sort of national health program has been considered. The American Medical Association (AMA), for obvious economic reasons favoring the medical profession, was and is opposed (Weeks & Berman, 1985). Although the Social Security Act (1935) included numerous programs (e.g., old-age pensions, unemployment insurance, maternal and child health programs, and the Public Health Service), it did not include health insurance. With the passage of Medicaid and Medicare in 1965, the needy and the elderly gained access to health care. Today, the federal government is paying a large percentage of health care costs in the United States (Weeks and Berman, 1985).

Nursing and nursing administration have not been actively involved with health care policy throughout the century. Involvement in health care policy is a tool that is largely unused by nurses (Benoliel & Packard, 1986). Recently, numerous nursing authors (e.g., Aroskar, 1987; Benoliel & Packard, 1986; Davis, Oakly & Sochalski, 1982; Holleran, 1985; McLemore, 1980) have encouraged nursing administrators to become knowledgeable about the policy process and to expand nursing's role in the policy-making process. Nursing administrators have an ethical and legal

responsibility to represent the public and be active in health care policy making. If the administrator is employed as a public administrator in a public organization, that responsibility becomes more paramount.

Nursing and Nursing Administration

Nursing licensure has been a continuous process during the entire century. Early in the century, nursing leaders were concerned with registering nurses. Early registration acts were based on the idea that a nurse operated under a physician's license and followed physicians' orders. Then the registration laws were changed about mid-century to define two levels of nurses: practical and professional. More recently, the laws were revised to acknowledge the expanded roles of nurses. Current acts define the independent role of nursing and the legal accountability of the nurse to the patient.

Early registration and later revisions were largely ignored except by some hospital administrators and physicians (Dolan, et al., 1983). Court cases challenging the laws as they have evolved and some research regarding violations of the law are discussed in detail later in this chapter. The statutes and case law over the century recognized the progressively autonomous nature of the

nursing profession. Currently, nursing is recognized as autonomous and distinct from medicine. Equally important for this dissertation is the treatment of nursing administration by the courts. Nursing administrators are in a health care management role, and therefore held to a higher standard of planning and providing care than are traditional staff nurses (Kron, 1981).

Nursing Education and Ethics

The institutionalized apprenticeship system of training nurses kept nursing education under the authority of hospital administrators and physicians. That situation changed in the 1960's and 1970's. Nursing leaders in the 1960's advocated higher standards for nursing education. The American Nurses' Association (ANA) stated that nursing education should be situated in colleges and universities and not in hospital diploma programs. Diploma programs decreased in number, and associate and baccalaureate programs increased (Dolan, et al., 1983). College-prepared nurses became more involved in management activities and less in direct patient care. The new managers focused on changing the legal definition of nursing in nurse practice acts and on revising the Code. They also focused on the accountability of the nurse as a patient advocate, the

development and dissemination of standards of nursing practice and the development of quality assurance movements.

According to Dolan, et al. (1983), the study of ethics has been part of nursing curricula for the entire century, although at the beginning of the century, the apprenticeship programs for nurses offered very little formal education and no formal courses specifically in ethics. In the early religious schools, a strong religious orientation for teaching ethics frequently prevailed, and ethical considerations of practice were usually considered within the context of Christian values. Another alternative was to teach ethics around a tentative code of ethics for nurses. A tentative code was viewed by some (e.g., Parsons, 1916; Robb, 1901) as a set of rules that could not begin to cover the many situations that arise to confront and confound the nurse. The answer instead was the development of character or right methods of reasoning about conduct. Formal ethical courses began to evolve later in the century as nursing education became more formal.

At the beginning of the century, a major emphasis was given to the character, etiquette and subservient obligations of the nurse. Following WW II, ethics became integrated into courses in "professional trends" and "issues in nursing." Since the 1970's, there has been a resurgence

of interest in the inclusion of ethics and applied ethics in nursing education. Required and elective courses in ethics are available in most nursing education programs today. In addition, fellowships for advanced study and research in health care ethics have been available to nurses through the Kennedy Institute at Georgetown University (Dolan, et al., 1983).

I reviewed all of the articles on ethical issues in AJN over the century. Considering its main theme, I placed each article into a personal, professional, or administrative category. I then reviewed the themes in each category. Personal character traits, conduct and obligations were the major themes of the articles categorized as personal. Clinical issues and rights were the major themes of the articles categorized as professional. Rights, policies, and cost containment were the major themes of the articles categorized as administrative. This research, which will be discussed in detail later in this chapter, showed a difference between the ethical concerns of the traditional nurse and the nursing administrator. That is part of a major thesis of this dissertation: There is a distinctive nature to the ethics for nursing administrators.

Distinctions

To understand the origin, nature, and validity of ethics for nursing administrators, certain distinctions need to be made. My thesis is that nursing is distinct from medicine and that nursing administration is distinct from traditional nursing. Therefore, nursing administrators, especially those employed as public administrators, are distinctive and have unique value sets and ethics. Historical developments, case law, statutes and ethical examples, as well as support from current literature and research, will be used as evidence to support the above assertions.

Nursing

At the beginning of the century, a nurse was an untrained "handmaiden" under the direction of a physician who was the "Captain of the ship" (Creighton, 1986). However, over the years, nursing has evolved into an autonomous profession.

Nursing is quite distinct from medicine. Nursing is a health-oriented profession which has a maternalistic approach with an emphasis on the preservation and the restoration of health. Medicine is an illness-oriented profession which has a paternalistic approach with an

emphasis on the diagnosis and treatment of disease. The most distinctive characteristic of nursing is the commitment to caring and the most distinctive characteristic of medicine is the commitment to curing disease. Nurses care for patients and physicians cure disease. Nursing is derived from the Latin word nutrio, meaning nurture. By contrast, medicine is derived from the Latin word medicus, meaning healing. Nurses are usually employees of hospitals and are predominantly female, while physicians are usually entrepreneurs and are predominantly male. Nursing is a middle-class profession and has basic educational requirements, while medicine is an upper-class profession with extensive educational requirements.

The educations for both these professions are quite different and specialized. The authority for either role is grounded in legal licensure which usually includes definitions of practice. Although there has been some controversy over the boundaries of the two professions, they have been legislatively and judicially recognized as two distinct professions.

Some of the most important pieces of legislation supporting the distinctive nature of nursing practice are the licensing laws and practice acts. Registration or licensure laws were originally enacted to assure that the

public was protected from incompetent practitioners. In addition, each state uses nurse practice acts to define and legitimize nursing practice within its boundaries.

The nursing licensure laws in each state delegate the authority to control admission to a state board of nursing. Functions of the various boards usually include: (1) determination of eligibility requirements for initial licensure, (2) approval and supervision of educational institutions of nursing, and (3) enforcement of restrictions through suspension, revocation and relicensure. Grounds for disciplinary action vary from state to state but may include: obtaining a license by fraud, immoral or illegal actions, performance of acts that may be specifically prohibited by the act and malpractice (Deloughery, 1977). Some research and court cases regarding such violations will be presented later in this chapter.

The initiative for organizing nursing came about at the turn of the century with a confederation of nursing school alumnae. Ten representatives of the then existing alumnae associations met in 1896 to set up the Nurses' Associated Alumnae, the organization which became the ANA in 1911.

The major early efforts of organized nursing were concentrated on obtaining state registration of nurses and a law that would control and standardize the various training

schools for nurses. Therefore, ANA moved to set up state organizations to do the necessary lobbying for state registration acts. The first to succeed was North Carolina in 1903. Later the same year, New Jersey, New York, and Virginia also succeeded. By 1923, all the states then in the Union, as well as the District of Columbia and Hawaii, had licensure for nurses (Bullough and Bullough, 1978).

There was very little opposition to early registration laws for nurses. It is clear that issues of power (control) over the nursing profession and the profit motive motivated the opposition. An analysis of the wording of twenty early registration laws, official reports of state nurses' associations, editorial articles and articles in the *AJN*, as well as other legislative journals and books was done by this author to gain insight into that opposition. The analysis of the early laws showed differences in the length and type of training required, the composition of the boards of examiners, levels of training, and the required age for registration.

Most of the laws required that an individual be 21 years old. A few of the earlier laws (e.g., Maryland, Colorado, and Washington D.C.) required an age of 23 years. Most states required a diploma for at least two years of training in a school affiliated with a general hospital or

sanitarium. A few laws (e.g., Maryland, Colorado and Idaho) required three years of training. All the laws examined required the individual nurse to be of a moral character or good moral character. At first glance, these criteria appear concerned with protecting the public from incompetent practitioners. However, upon closer examination, the power and profit motives emerge. Hospital and sanitarium based training schools often used students as inexpensive labor. In addition, mature women were less likely to marry, were more morally mature and required less supervision.

A concern of some physicians was that registration might raise the cost of nursing service to an unaffordable level for the poor. Perhaps the poor would only be able to hire untrained nurses. Some physicians continued to hire unlicensed persons for caring for the sick because the "fees were more in alignment with the patient's welfare" (Quarterly News, 1936). Such concerns brought up the idea of different levels of nursing and the compensation for the different levels. Missouri's early law required the licensure of attendants and the American Hospital Association recommended two levels of nursing with a minimum level of training for each (Aikens, 1910). The Journal of the Assembly of the State of New York at their one hundred and twenty-sixth session (1903) showed discussion supporting

untrained nurses. A synopsis of a 1913 proposed amendment in New York emphasized that it was not ethical to provide the poor with nurses having less training than the rich (NYSNA, 1913). Therefore, New York amended the law recognizing only the title "nurse" and setting the minimum training at two years. The concerns of some of the physicians and the AHA were more self-serving economic concerns than economic concerns for the individual patients. Physicians and hospital administrators saw nursing as a valuable service that could provide profit.

The Illinois bill met with an opponent who was the college president of a training program that was only three months long (ANA, 1903). That state nurses' association successfully lobbied against that opponent. In 1907, correspondence and short courses in Pennsylvania objected to the bill for nursing registration. The state nurses' association felt that it was better to suffer defeat than to accept a law that lowered nursing educational standards (AJN, 1907). Correspondence and short-course schools retarded the registration movement in some states. Again, this opposition was self-serving and profit motivated. The various legislatures eventually recognized this, as evidenced by their enactment of the laws requiring a minimum of two to three years of training in a school affiliated

with a hospital or sanitarium.

An analysis of the wording of the early registration laws showed variance in the composition of the state boards. Apparently some physicians and administrators attempted to maintain control over the nursing profession by manipulating the composition of the registration boards. One state (Louisiana) had a board of physicians because nurses were traditionally women and women could not hold a state position (Doyle, 1915). My analysis showed that North Carolina, California, Pennsylvania, Idaho, Michigan and Vermont originally placed nursing registration in the hands of boards composed of physicians and nurses. One argument for a mixed board was that while nurses were subordinate to physicians, both should be represented on the boards. Even in their legal status, nurses should be subordinate to their medical associates. Another argument was that additions of physicians and hospital administrators lend dignity to the boards through their advantages and experience (Doyle, 1915).

In Massachusetts, the Board of Medical Examiners opposed the 1904 bill. They attempted to place the registration board in the hands of the Medical Commission. The nurses in that state refused to accept such an arrangement and they killed the bill (AJN, 1904). The same

issue came up in Iowa and the bill was amended to provide for a board of nurses.

A synopsis of a proposed amendment in New York (NYSNA, 1913) summarized the argument for an all nurse board. Nursing should have the privilege that other professions have to develop standards and administer its laws. To do otherwise would involve nursing in medical politics. Numerous or all of the medical schools would demand representation. That synopsis also stated that no man would find the time to serve on a nursing board. However, some (e.g., North Carolina, Pennsylvania, Idaho, Michigan and Vermont) nurses' associations accepted a mixed board. They realized that the benefits of registration that included enhancing training schools, standardizing education, protecting the public and protecting other nurses outweighed the disadvantages of a mixed board.

Early opposition was not concerned with nurses threatening the role of medicine or of practicing medicine, but with self serving interests centered around power and profit. The original registration laws and amendments served to raise public awareness of the concerns of the profession and created the impetus for the profession to organize. Nurses gained respect as a profession because it proved that it could deal with opposition and its own

problems. The registration movement also achieved its goals, including protecting the public by requiring minimal qualifications and prohibiting unqualified individuals from practicing. The registration process, administered by boards of experts in the field is a valid way of holding licensed practitioners accountable to appropriate professions standards.

Since none of the original registration acts defined the scope of practice, they were not referred to as nurse practice acts. A "registered nurse" was defined as someone who had attended an acceptable nursing program and passed a Board examination, rather than one who engaged in a specific type of practice. This definition emphasized the educational and early reform efforts to focus on improving the training, rather than the practice of individuals (Roberts, 1954).

New York was firmly convinced that a standardized education for nurses was the way to assure that the public was protected from incompetent practitioners. That state successfully supported amendments to the laws that standardized education by requiring that the schools be approved by the State Education Department. New York also successfully supported amendments addressing violations of this act, reciprocity of licensure in other states, and

hiring a nurse (as opposed to a physician) to be the Secretary of the Board of Nurse Examiners (NYS Nurses' Association, 1913).

By mid-century, nurse practice acts had evolved from simple registration acts to more complex regulatory statutes that included definitions of one or more educational levels of nursing practice (e.g., practical and professional nurses) and specific definitions of nursing practice (AJN, January, 1952). To assist with the lobby for definitive licensure laws, ANA in 1955 adopted a definition of nursing that renounced diagnostic and treatment functions of nurses. It seems that nurses themselves sought to avert any possible opposition to the new laws by denying themselves the responsibility to make therapeutic or diagnostic decisions. The ANA definition of nursing drew a rigid line between "nursing" and "medical" practice by declaring that the practice of professional nursing should not include "acts of diagnosis or prescription of therapeutic or corrective measures" (ANA, 1955). ANA, representing the nursing profession, stated that as the nursing role has expanded, these terms have become problematic. Referring to some judgments as "nursing diagnosis" has led to some resistance by some physicians who interpret diagnosis in the narrow sense of medical judgment that is believed to be the sole

responsibility of the physician (ANA, 1955).

That definition of nursing and the mid-century amendments were moves towards being specific about the definition of nursing. However, with the rapid explosions in science and technology and the expanding nursing role, nurses increasingly needed to diagnose, treat, and make therapeutic decisions. Specific or narrow definitions of nursing practice needed to be amended frequently.

By the 1970's, early definitions of nursing practice in state statutes were considered obsolete. Minimum standards were too low and restrictive; did not identify an autonomous professional role; emphasized the dependent function placing the nurse under the jurisdiction of another professional; were illness-oriented; and did not reflect society's needs (Dolan, et al., 1983).

The various state legislatures have used several ways since the early 1970's to broaden the scope of nursing practice. These methods include specific recognition of nursing specialties, expansion of the basic definition of nursing to incorporate responsibility for treating and diagnosing patients, and the use of administrative roles. The trend is toward broadening the language of the various statutes and rules to recognize the expanded role of the nurse and to prevent the need for frequent revisions

(Trandel-Korenychuk and Trandel-Korenychuk, 1978).

The new revisions generally grant authority to the state board of nursing to promulgate regulations regarding permissible functions. The board of nursing then enforces and administers the regulations (Rhodes and Miller, 1984). Early nursing efforts to be self-regulating, as opposed to being regulated by medicine, have been successful. This success is further documented by research and the courts.

A search of the literature revealed some research and several court cases that have dealt with the new nurse practice acts. Murphy and Connell (1987) did a study to describe and explore the relationships shown in sociodemographic variables of violators and non-violators of Arizona's Nurse Practice Act. Descriptive data (age, gender, marital status, basic nursing education, clinical area of practice, employing agency, and type of violation) were collected from 100 records of investigations and hearings conducted by the State Board of Nursing. All of the subjects were charged with unprofessional conduct, either for incompetency or substance abuse, and all received disciplinary action. Statistically significant characteristics of violators were identified. Ten percent of the nurse offenders worked in nursing homes, as compared to five percent of all nurses in the state. Fifteen percent

of the nurse offenders were employed through a registry as compared to 1.6 % of the state population of nurses. A majority (54 %) of all the nurse offenders were medical-surgical nurses, as compared to 37.4 % of all nurses in the state.

In the first reported judicial interpretation of the modern nurse practice acts, Shermchief v. Gonzales (1983), the Missouri Supreme Court decided the "new functions for nurses delivering health services" may evolve in the absence of statutory constraints. The suit involved the expanded roles of two nurses providing extensive family planning services in a federally funded program serving rural areas in Missouri. The nurses performed a variety of diagnostic and treatment functions, including breast and pelvic exams, lab tests and birth-control counseling and were providing birth-control products.

Shermchief identifies the challengers to the expanded role of the nurse. The case was a civil action for injunctive relief involving not the state nursing board, but the medical licensing board. That board petitioned the trial court to declare the nurses' acts to be practicing medicine without a license.

The trial court held that the acts were the unlawful practice of medicine. The case was then appealed to the

Missouri Supreme Court. The principal issue was whether the nurses were practicing nursing as defined in the state's nurse practice act.

When the Supreme Court looked at the act to determine whether the nurses were practicing within the scope of nursing, it found an open-ended definition of professional nursing introduced by the phrase "including but not limited to....". The court said that the use of this language "evidences an intent to avoid statutory constraints on new functions for nurses delivering health services." When the court compared the law with an earlier version, it noted that the requirement for a physician to supervise nursing functions directly had been eliminated. This was also interpreted to be a "legislative desire to expand the scope of authorized nursing practice." All of the sitting Supreme Court judges concurred (agreed) with Judge J. Welliver but did not write individual opinions. The court specifically held that with the expanded role of nursing, nurses may render diagnosis and treatment in accordance with standing orders or protocols and that nursing is distinctive from medicine. Additional legislation authorizing expanded nursing practices seemed unnecessary to the Missouri court.

Shermchief clearly recognized nursing as an autonomous profession. Courts generally hold that persons who

undertake the activities of a given profession are held to the standards of that profession (Murphy 1987).

By recognizing a standard of care for nurses that is different from physicians, courts recognize that nursing is a separate and distinct profession. In Fein v. Permanente Medical Group, the California Supreme Court cited the California Nurse Practice Act and concluded that the nurse practitioner's conduct should not be measured by the standard of care of a physician.

Several hours after a nurse practitioner examined the plaintiff and gave him medicine that her supervising physician had prescribed, the patient returned with similar complaints. He was examined by a physician, who also failed to order an electrocardiogram. The next day the patient had a heart attack. The plaintiff alleged he was injured by the failure of the medical group to diagnose promptly and treat an impending heart attack. Both parties appealed from a judgment awarding the plaintiff about one million dollars. One of the contentions was that the trial court misinstructed the jury on the standard of care by which the nurse practitioner is to be judged. The California Supreme Court held that the jury should not have been told that "the standard of care required of a nurse practitioner is that of a physician." However, the court concluded that the error

did not affect the judgment in the case and the error did not warrant reversal. With Justice J. Kaus presiding, the judgment of the trial court was affirmed. Justices Broussard, Grodin and Lucas concurred (agreed) with Justice J. Kaus without writing their own opinions. Chief Justice Bird and Justice Mosk dissented on several issues regarding the amount and type of judgment to be awarded. Nevertheless, the Fein decision concomitantly recognized nursing as a profession separate from medicine.

Another method of measuring court recognition of the autonomous function of nursing is to look at nurse liability for malpractice. Cases in which nurses were found liable (e.g., Darling v. Charleston Community Memorial Hospital and Muller v. Likoff) even though some had followed physicians' orders are considered evidence of autonomous, independent function. In Darling v. Charleston Memorial Hospital (1965), the nurses, along with the physicians were found negligent in a case involving a broken leg which turned gangrenous and had to be amputated. In Muller v. Likoff (1973), the evidence showed that the negligence consisted of a nurse giving a medication inappropriately. The fact that nurses are acting in accordance with the orders of the physician does not excuse them from using independent judgment.

Over the years, the courts have consistently held nurses responsible for protecting the patient or acting as a patient advocate, especially in the presence of inadequate medical care. Nurses are expected to go beyond informing the physician of a threatening finding if the physician fails to act. Nurses have an ethical and legal duty to report their concerns through nursing administrative channels.

York v. Northern District of Surry County is a case that illustrates the obligation that a nurse has to question a physician's order which was "obviously negligent." The nurse knew that the patient was not to go into labor and was a repeat classical Caesarean section case. Instead, the patient was allowed by the physician to labor for several hours. Her uterus ruptured and an emergency Caesarean was performed. The Yorks filed a complaint against the hospital and the doctors alleging that Mrs. York and her child sustained serious and permanent injuries as a result of negligence. The Superior Court, Surry County, entered judgment for the hospital and the doctors. The Court of Appeals of North Carolina held that the trial court's instructions on whether the child's injuries were proximately caused by the hospital's negligence were incomplete. Therefore, the Court granted a new trial in

part. The trial court's instructions specifically directed that the jury could find for the plaintiffs if the jury found that the nurse breached her duty not to obey the physician's instructions which were "obviously negligent" and which deferred the immediate repeat Caesarean section. It was clear that the nurse knew that the patient was to have a repeat Caesarean. Accordingly, the Court of Appeals, with Justice J. Martin presiding and Justices C. J. Hedrick and J. Green both concurring, ruled that the rupture of Mrs. York's uterus occurred as a direct and proximate result of the hospital's failure through its agents (e.g., nurses), as well as the physician's failure to promptly and properly perform a repeat Caesarean section.

According to McKinlay (1982), there is a trend away from a protection of the health care industry and individuals or institutions who provide care, to a philosophy of accountability. This reflects the increasing public concern and demand for health care. For example, before 1960, a majority of states legally protected charitable and non-profit institutions from liability for harm to patients. That doctrine has been overturned. Today, courts define notions of institutional responsibility for health care activities that take place in health care settings. It is universally agreed that institutions are

responsible for everything that goes on within their walls, including the actions of individual practitioners (McKinlay, 1982). The Darling and York cases, discussed previously, illustrate that proposition. The Darling (1965) case was an historic first to impose a duty on nurses to go beyond informing the physician of a threatening finding. Nurses in both cases were held responsible for failing to go through nursing administrators to hospital administrators so that appropriate action could be taken when the physician failed to act.

In conclusion, nurses' struggles to adhere to a distinctive role throughout the century have been demonstrated by the evolution of licensure laws and nurse practice acts. The legal authority for a distinctive role is grounded in current statutes which include broad definitions of the scope of practice including diagnosis and treatment. Nurses today are designed to function independently as autonomous professionals. Court cases (e.g., Fein and Sermchief) demonstrate that nursing is regarded as a distinct profession. Courts expect nurses to exercise independent judgment in regard to following physicians' orders (e.g., Darling and Muller). More recently, trial courts (e.g., Darling and York) have expected nurses to take affirmative steps, as patient

advocates, to protect the patients from negligent acts of physicians.

Nursing is based on distinctive values such as caring and has a distinctive ethical code, as discussed in Chapter Two. Nursing ethics need to be recognized as being different from those of medicine. For example, the issue of informed consent is an ethical concern for both physicians and nurses. Most now agree that what constitutes informed consent is active shared decision making between the health care provider and the patient. Preserving the fundamental right of self-determination is legally mandated (Silva and Zeccolo, 1986).

A physician has an ethical mandate to obtain an informed consent before proceeding with a surgical procedure. However, in the same case, a nurse acting as a patient's advocate is ethically mandated not to proceed with the same surgical procedure if she determines that the patient does not understand the procedure. The ethical obligations of the nurse and the physician are quite different.

To carry this claim of distinctive ethics one step further, we must recognize that ethics for the nursing administrator are distinctive from those of the traditional nurse. For example, in the above discussion of informed

consent, the ethical obligations for nursing administrators are different from either the nurse or the physician. The nursing administrator must plan for and provide a process to assure informed consent. The nursing administrator needs to formulate and implement sound policies to insure that all of the recommended components of informed consent are provided and that informed consent is documented. A consistent monitoring system is also in the realm of the nursing administrator (Silva and Zeccolo, 1986).

Nursing Administration

The distinctive role of the nursing administrator has been recognized by the courts. Supervisors and nursing administrators are not liable for the negligent act of a subordinate person under the doctrine of respondeat superior. Supervisors can be found negligent for harm to a patient only if the supervisor inaccurately assessed the patient's needs or the subordinate's abilities when assigning care, or if the supervisor knew or should have known the subordinate could not safely meet the patient's needs without assistance and failed to provide the assistance needed. In a rather infamous case, Piper v. Epstein (1945), a supervisor was found liable for the death of a patient caused by an infection from a sponge left in

the patient's abdomen during surgery. The case showed that the person assigned to do the sponge count was not competent, a situation resulting in a miscount. The nurse miscounted the number of unused sponges on the operating table after surgery. The supervising nurse was responsible for counting the sponges before surgery and after surgery. The supervising nurse did not recheck the count with the nurse after the surgery. Therefore, the court ruled that there was no negligence by the nurse and that the supervisor was responsible for the error. Justice O'Connor concurred with Justice Niemeyer's opinion to reverse the judgment against the hospital and the nurse and to affirm the judgment against the nursing supervisor. The hospital, being a charitable institution, contended that the rule of respondeat superior did not apply, and therefore, it was not liable for the negligence of its agents or servants.

A Canadian case (Laidlaw v. Lions Gate Hospital, 1969) also illustrates that nursing administrators are held to a higher standard in planning and providing care. Mrs. Laidlaw was taken, unconscious, to the recovery room after an uneventful cystectomy. On that day, the staff consisted of a charge nurse and a staff nurse to care for five expected post-operative patients. The charge nurse allowed the staff nurse to go for coffee when three patients were in

the unit. The two remaining patients arrived in close proximity to each other with only the charge nurse in attendance. Mrs. Laidlaw suffered a respiratory arrest while the charge nurse was attending to other duties. She suffered permanent brain damage, requiring life-long care. The court stated that the problem was the lack of staff and the duty to resolve such staffing problems came under the department of nursing. The court found that the charge nurse was negligent in permitting the staff nurse to leave when she expected or should have expected the arrival of the other patients. She should have arranged for staff relief.

In Arkansas State Board of Nursing v. Long, 1983, the board of nursing held that a nurse administrator's conduct constituted negligent and unprofessional judgment with respect to the death of a patient. The patient died during a period of time (i.e., one to one and one-half hours) that floor waxing prevented access to the elderly patient. The patient was restrained in her overturned wheelchair, when discovered by the staff. During the appeal, with J. Corbin presiding, the court held that there was no substantial evidence to support the board's decision that the nurse administrator's conduct constituted negligence or unprofessional judgment. The court criticized the Arkansas State Board of Nursing for "cross-examining every area of

nursing they could think of," when, in fact, the nurse was functioning in an administrative role. Ms. Long, the administrator of a nursing home, reacted immediately when she was notified that the housekeeping staff had waxed the entire floor leading to the rooms containing twenty-four patients who could not care for themselves. She went to the floor and immediately told the housekeeping staff that the policy in the future would be to wax only half of the floor. The administrator took administrative action and implemented a corrective policy before the discovery of the unfortunate death of the patient. It was clear that the court did not hold the nursing administrator to a standard of a traditional staff nurse, but to the standards of an administrator.

Nurse administrators are no longer only health care providers; they are health care managers, a role which requires a higher standard in planning and providing care. Nurse administrators are now held accountable for their assessments and actions in that role (Kron, 1981). They are liable for their independent judgments.

Recognizing that nurse administrators are unique leads to the need to recognize that the ethics for nursing administrators are also unique. In addition, ethical mandates for nursing administrators employed as public

administrators can be quite different than those employed in private (e.g., Catholic Hospitals) organizations.

Normatively, the Catholic Church mandates that Catholic Hospitals respect human nature, as well as enhance human dignity and purpose. Administrative discretion is guided by their belief in Christian values. That belief means that values (e.g., sacrifice, generosity, caring, or justice tempered by mercy) transcend the values of expediency or efficiency often guiding public organizations. For example, with the issues of the right to die or abortion, the nursing administrator in a Catholic hospital might be more inclined toward the ideal of the sanctity of life, while the nursing administrator in a public organization might be more inclined towards the ideal of the quality of life or individual rights to choose.

The ethics for nursing administrators are also unique from those of the staff nurse. The use of the example of short staffing can help illuminate this point. The ethical issue of the allocation of scarce resources (e.g., staff) is of concern to both the staff nurse and the nursing administrator, but the focus of the concern is quite different. The nurse is oriented toward direct patient care, while the nursing administrator is oriented toward managing nursing service. Nursing administrators often need

to make decisions to reduce staffing on one unit, in order to allocate staff in the fairest way possible. The staff nurse on that unit may see this as limiting her ability to provide quality patient care to individual patients.

Considerations of individual patient rights may be slighted in favor of more utilitarian considerations of efficiency, economic stability, or fairness.

The competing ethical claims surrounding the abortion issue are another example of the differences between the ethical obligation of the nurse and the ethical obligation of the nurse administrator. According to the 1973 U.S. Supreme Court interpretation of the U.S. Constitution, women have a right to have an abortion under certain circumstances. Disagreement on the morality of abortion continues and implementation of legalized abortions has been a problem. Nurse Administrators have an ethical obligation to see that the woman's right to abortion is upheld and to enforce staffing policies to cover abortion units. The staff nurse has the ethical obligation to provide quality patient care. However, some nurses feel that abortion is ethically wrong. Religious freedom as well as personal liberty are guaranteed by the U.S. Constitution. In this case, to slight individual rights (e.g., the patient's right to abortion) in favor of a more utilitarian consideration of

efficiency would not only be unethical, but also illegal. To slight the nurse's right to religious freedom would also be wrong. Decisions in situations of this sort need to be made in a caring manner. The collective caring model presented in this dissertation could be useful to the nurse administrator. Committees (collectives), composed of staff, patient representatives and administrators, could develop and distribute clear guidelines to help alleviate some of the concerns regarding the abortion issue at the personal, profession and administrative (both public and private) levels. For example, it is generally agreed that staff who believe in a patient's right to choose are the most desirable staff for abortion units. Administrators, especially those who take an oath to uphold the Constitution, need to address the personal liberties and religious freedom of both patients and staff. In addition, administrators in Catholic health care facilities will need to consider Christian values, as well as other directives or frameworks.

In addition to having a framework to guide ethical decision making in the above examples, knowledge about the U.S. Constitution is also essential. Nursing administrators, especially those employed as public administrators, need to be constitutionally competent in

order to understand the legal and ethical mandates stemming from that document, the supreme law of the land. Those mandates are closely related to the values of the American people to which the public administrator needs to respond.

Public Administration

The nature of the role of nursing administrators employed as public administrators is distinctive. They incur unique ethical responsibilities and obligations. The functioning of a public administrator must be consistent with the ethical principles of the Constitution. The ethical climate that the administrator establishes and maintains must support the supreme law of the land and respond to public values or the public interest.

The American Nurses' Association's Nursing: A Social Policy Statement (1983) emphasizes the mutually beneficial relationship between society and the profession. Nursing needs to be aware of the public's values and needs. ANA clearly suggests that the profession must serve and must be perceived as serving the public interest in the area of health care. Numerous authors (Dvorin, 1972; Meideiros and Schmitt, 1977; Rohr, 1989; and Warwick, 1981) have emphasized the primary significance of the public interest for public administrators.

According to Warwick (1981), the public interest is a set of conditions or outcomes providing advantage to the society as a whole. Its' absence can be noted in undue concessions to special interests and in violations of procedural safeguards designed to protect the public at large. The public administrator needs to be concerned with promoting the common good. The pursuit of personal, organizational (bureaucratic), professional, and constituency interests is acceptable to Warwick provided that it does not work against the public interest or create other significant harms.

Rohr (1989) stresses that public administrators have an ethical obligation to respond to public values, specifically constitutional or regime values, because public administrators at all levels of government take an oath to uphold the U.S. Constitution. Telephone requests to the Secretary of State Offices in the northeast for copies of the oaths that public officials take produced several examples (See appendix H). The results of that survey show that oaths are generally taken by elected or appointed officials and federal employees (e.g., military nurses or VA nurses). Generally, nurses employed as state employees are not required to take an oath. Exceptions existed in some states (e.g., Pennsylvania and Rhode Island) in regard to

some categories (e.g., corrections) which required oaths and one state (New York) requires all state employees to take an oath.

Although many publicly-employed nurses do not take an oath to uphold the Constitution, they should be held to some sort of public interest standard. The Constitutional tradition offers an appropriate method to figure out just what the public interest might be in a particular case (Rohr, 1989). In addition, nursing administrators should uphold constitutional principles on the general grounds of citizenship.

Those nurses taking an oath to support the constitution need constitutional competency and are obligated to respond to constitutional or regime values. In addition, nursing administrators have an ethical obligation to establish and maintain an ethical climate to support constitutional values. Nursing administrators employed as public administrators have considerable discretion to establish organizational policy and public policy and should use that discretion to support constitutional values.

One concern that promotes interest in the ethics of public administrators is based on the discretionary power of the public administrator. Public administrators exercise considerable discretion in formulating, implementing and

evaluating public policy. Several authors (Dvorin, 1972; Meideiros and Schmitt, 1977; Rohr, 1989; and Warwick, 1981) have discussed this issue. Rohr (1986) states that it is appropriate for public administrators to use their discretion in favor of policies they think support the public interest, if the public interest is assessed against the broad background of constitutional principles supporting individual rights. According to Warwick (1981), the public administrator needs to be concerned with the public interest to promote or protect the common good. I am convinced that there needs to be a balance or a caring connection between individual rights and the common good. A relationship between the two must exist; it cannot be one or the other. Ethical decision making needs to be based on balancing benefits against potential harms with a strong community or collective commitment. Such decision making would be appropriate regardless of whether the nursing administrator is employed in a public or private (Catholic) institution. Basic values might be different, but the balance and the concerns for the collective (public or community) should be similar. For example, with the issue of the right to die or self determination, a nursing administrator in a Catholic hospital might be more inclined toward the ideal of the sanctity of life, while the nursing administrator in a

public organization might be more inclined toward considering the quality of life. Nevertheless, either nursing administrator needs to be able to accept public input in the form of policies or laws and act on those guidelines. For example, a new concept, often referred to as "living wills" allows individuals to maintain the right to self-determination. Living will legislation has been passed in most states. In addition, all organizations (public or private) receiving Medicare or Medicaid patients must provide written information about living wills and their rights.

Nursing administrators are in a position to affect public health care policy. Public Law 93-641, The National Health Planning Resources and Development Act (1975), designated nursing as one category of health care provider to be represented on the governing bodies of the planning agencies established by the act. The act established local health systems agencies and made them responsible for planning and developing services, manpower and facilities to improve the public's health. That act is an example of the legitimate right of nursing to participate in the governing of the health care policy process. Nursing administrators who take an oath need to be concerned with and knowledgeable about the public interest and the values expressed in the

U.S. Constitution. Nursing administrators involved in policy processes need to respond to society's values and interests. This is a unique role that needs to be recognized as such.

Public organizations are quite different from private organizations. Public organizations are usually owned and funded by the government (Wamsley, 1973). Their incentives, constraints, and values are significantly influenced by public scrutiny, public expectations, and extensive legislative, judicial and regulatory prohibitions (Fottler, 1981; Rainey, Backoff & Levine, 1976). Different dependencies on different political groups and organizations (each with different goals) in the external environment create different institutional values, goals, incentives and constraints (Fottler, 1981; Neuman & Wallender, 1978). Goals also tend to be multiple, vague and conflicting. Decision making in public organizations is more apt to involve inputs, resources or funding, rather than outputs (Neuman & Wallender, 1978).

For example, health care resources are becoming increasingly scarce and expensive. In part, this is due to the public's interest in containing the costs of health care. Every aspect of care, including staffing, is in short supply. Deciding who will receive care and when, as well as

on what basis, is becoming increasingly difficult. The goals of cost containment and good quality nursing care can conflict. The defense and justification for nursing costs as they affect patient outcomes is quite difficult. In the Laidlaw case, the court held that the short staffing was a problem for which the nursing department administrators were responsible. However, the nature of public organizations discussed above constrains the administrator's choices.

Fried, (1983) considers the time and attention of the nurse as a scarce resource in a hospital and feels it is the responsibility of the hospital bureaucrat to provide for the welfare of populations as a whole in a just manner. It is up to the public administrator to manage things so that quality care is distributed in a fair and equitable way. Competent public administrators in health care settings can make a positive contribution by linking democratic governance to health care settings (Fried, 1983).

Milio (1984) used an example of how a high infant mortality rate in Michigan in 1981 was related not only to federal cutbacks in maternal-child health and family planning funds, but also to reductions in welfare and food stamps as well as in Medicaid and other public assistance programs. Nursing became actively involved. Alternative policies with their probable outcomes were analyzed and

positive steps were taken to reduce the infant mortality rate. Nursing administrators employed in those public organizations had an impact on those cutbacks and positively influenced certain aspects of those health care policies.

Public organizations need to be concerned with and are accountable for a wider range of effects on society than are private organizations (Lynn, 1984). For example, numerous court cases (e.g., Muller, Darling, and York) have emphasized the importance of protecting the patient and the public from incompetent practitioners. Whistleblowing as an advocate for the patient or the general public is an accepted aspect of the role of the nurse and the nursing administrator.

The conclusion of this argument is that the role of the nursing administrator employed as a public administrator and the ethics associated with that role are unique. Nursing administrators employed in private (Catholic) institutions are guided by different values and standards than those employed in public institutions. The issues relating to staffing for abortion units, right to die issues and whistleblowing were used as examples to illustrate those differences. Administrative discretion in public organizations needs to be guided by a concern for the public interest and public values. Public administrators need to

have constitutional competency and knowledge about the unique nature of public policy and public organizations. Also, public administrators need to enhance public confidence in their integrity and ethical practice. They are generally held to higher standards than administrators in the private sector. They need to establish an ethical climate that is conducive to decision making and to action that supports public interests and public values in the public sector.

Ethical Concerns

As nursing leaders began to organize at the beginning of the century, they recognized the need for a representative nursing journal. One of the first activities of the Associated Alumnae (the ANA after 1911) was to appoint a committee to investigate how a journal could be started (Deloughery, 1977). The American Journal of Nursing (AJN) was initiated as a joint stock company in 1900. By 1912, the Journal owned all the stock so it was truly the property of American nurses, controlled by their association, and its official organ.

The Journal's three functions have stood the test of time and are still the same: (1) to be a continuous record of nursing events; (2) to be a means of communication among

nurses; and (3) to be a means of "interpreting nursing to the public." As developments in the profession demanded it, the Journal increased both in content and in variety of subjects discussed. The AJN has served as a unifying force on many issues; for example: licensure, education, employment standards, ethics, women's suffrage and sex discrimination (Deloughery, 1977).

Because AJN is owned and operated by nurses and has been published continuously since 1900, it is considered a forum for the concerns of nurses. All of the issues of AJN from 1900 through 1989 were hand searched for articles focusing on ethics. "Ethics" was also cross-checked in all of the cumulative indexes for the same period. The articles found with ethical themes were classified according to personal, professional or administrative content.

A graphic rating scale, using short descriptive phrases derived from the definitions in this research study, was used to classify an article, according to the major theme, as either personal, professional or administrative ethics. The rater read the article, and placed a check in one of three columns titled personal, professional or administrative. The indicators listed on the scale were: (1) personal ethics- broad systems of principles used for moral guidance (e.g., personal character traits, personal

conduct, or personal obligations); (2) professional ethic-
broad systems of principles professionally sanctioned and
used for ethical decision making (e.g., professional
conduct, rights, scope of practice); and (3) administrative
ethics- broad systems of principles professionally
sanctioned and used for ethical decision making (e.g.,
whistleblowing, delegating tasks, and allocating scarce
resources).

Although inter-rater reliability was not a problem with
this study, because the author was the only rater, a
reliability coefficient (.90) was ascertained for the sake
of consistency and replication. In 90% of the cases, two
coders agreed on whether the main theme of a sample of 30
published ethical articles were classified as personal,
professional or administrative ethics. In addition, one
ethical concern (abortion) was the topic of four articles in
one journal (AJN, January, 1972). Those article are covered
here in the text to show how one article on abortion,
depending on the major theme, was mutually exclusive and
could be rated as either personal, professional or
administrative. A careful review of those four articles
should also ensure reliability and replication of this
research.

Ethical themes (e.g., collective bargaining, staff

incompetency, abortion, resuscitation policies, and informed consent) could be classified as either professional or administrative, depending on the main focus of the article. For example, in the January 1972 issue of AJN there were four articles on abortion. I placed three articles in the professional category and one in the administrative category. Keller and Copeland's article had an ethical theme of concern to the professional staff nurse. It discussed counseling as a positive intervention to gain insight into feelings and attitudes to help resolve moral or ethical conflicts of patients and staff. These authors strongly advised against forcing anyone opposed to abortion to work with abortion patients. This would only create a belligerent, dissatisfied staff and intimidate patients. The right to privacy and quality nursing care were paramount considerations. It was felt that caring staff would create an atmosphere of safety and acceptance. Such an atmosphere would encourage the patient to express anger and frustration and to become aware of their sources (Keller and Copeland, 1972).

Another professionally categorized article written by Branson (1972) in that same issue was the result of a survey of 50 nurses in Hawaii, two and a half years after a liberal abortion law was enacted. The survey recorded the responses

of nurses to the law and their jobs. Twenty-eight of the 50 nurses interviewed would actively participate in the care of patients who choose to have an abortion. Reasons given by those who opposed the law or who would not work in hospitals with physicians who advocated or performed abortions included the following types: religious and conscientious; ethical, associated with their feelings about nursing; and social, in that they saw abortion as a form of murder (Branson, 1972).

The third article I categorized as professional was an anonymous account of a personal experience by a nurse who decided that she had to have an abortion. One goal for sharing the experience was to keep the public informed on all planes of health concerns. She stated that the experience made her a much more perceptive and understanding person with the ability to be a more supportive and tolerant nurse.

The focuses of those three articles were quite different from that of the article by Felton and Smith in the same issue which addressed administrative concerns about abortion service. Felton and Smith advocated guidelines and policies to enhance the care of abortion patients and reduce adverse staff reactions. Nursing administrators need to anticipate the problems which cause frustration and

floundering in order to address those concerns with affirmative policies. The authors encouraged eleven policies addressing such concerns as admitting procedures, segregating abortion patients, using technical language, evaluating services, educating staff, counseling patients and staff, and staffing appropriately. In another AJN article in 1980, Davis addressed how staffing for abortions in a small community hospital was resolved. The administrators agreed that nurses would not be made to rotate into the abortion clinic against their religious beliefs and that nurses who did not have that ethical stance would work there. From the review of these articles I concluded that the ethical concerns about the abortion issue are quite distinctive for the nursing administrator. This research project documents that point. The administrator was concerned with the quality of patient care, adverse staff reactions and policies, while the professional staff nurse was concerned with personal ethical conflicts and individual rights. In addition, the articles recognized that professional staff nurses and administrators differ in their personal belief systems. Nursing administrators need to be cognizant of the different opinions regarding this issue. Current law generally supports abortion under certain circumstances. These circumstances vary from state

to state and there are continued attempts to change the law.

The time periods of this research project depict the early years of the century (1900-1939), when nurses were beginning to organize, were concerned with improving the professional image, and were employed in the home; the middle of the century (1940-1959), when nurses were beginning to be employed in large numbers in hospitals, when a formal professional code was accepted and when the image of nursing had improved to the point where it was an acceptable career; and the later years of the century (1960-1989) when nursing became an autonomous profession, when nursing administration was emphasized and when modern technology, scientific advances and cost containment created ethical questions never before imagined.

During the first of the three designated periods (1900-1939), AJN published 119 articles with ethical themes. Twenty-five were classified as having personal content, 76 as having professional content and 14 as having administrative content. Most of the articles were published under the regular column entitled "Ethical Problems." The themes of ethical articles with personal concerns included: personal character traits (e.g., honesty, diligence), personal conduct (e.g., social hours, eating etiquette, dress), and personal obligations (e.g., marriage, family,

church). Ethical themes with professional content included: professional conduct (e.g., professional relationships, obligations, advertisements, fraudulent behavior, competent behavior), the need for a professional code, incompetent physicians, the scope of nursing practice, standards, and the economic security of nurses.

Ethical themes with administrative content included: nursing school administration, teaching ethics, delegating tasks, and unfair employment practices (e.g., poor pay and poor training). This research correlated with the historical development of nursing ethics presented earlier in this chapter. At the beginning of the century concerns were focused on improving the image of nursing. Then the concerns in the middle of the century focused on a formal professional code.

In the middle of the century (1940-1959), AJN published 31 articles with ethical themes. One had personal content, 30 had professional content and no articles were found with a focus on administrative content. The article that was classified as personal included an ethical call to maintain a high moral (religious) character. Professional themes included: the Code, professional conduct and image, collective bargaining, problem solving steps, and integration.

During the later part of the century (1960-1989), AJN published 200 articles with ethical themes. Of those, 185 had professional content and 15 had administrative content. Professional concerns included: patient's rights (e.g., patient's bill of rights, confidentiality, self-determination, informed consent); technological, medical or clinical issues (e.g., abortion, sterilization, insemination, bioengineering, organ transplants, death and dying, artificial hearts, AIDS, severely impaired newborns); nurse's rights and role (e.g., conscientious refusal, due process, wrongful dismissal, discrimination, expanding role, patient advocacy); values clarification and professional conduct (e.g., law cases, competency, professional image, standards and whistleblowing). Administrative concerns included: nurses' rights (e.g., staffing for conscientious refusals and unjust employment practices), resuscitation policies, health care policies, public rights (e.g., right to information, to self-determination, to competent treatment), cost containment and scarce resources, as well as ethical rounds and ethics committees.

This research project confirmed and paralleled the concerns of nurses throughout the century presented earlier in this chapter, with a special emphasis on ethics. Ethical concerns at the beginning of the century were focused on

improving the image of nursing. In the middle of the century, the focus was on a formal professional code and at the end of the century, nursing ethics exploded. Clinical issues and rights were the major themes of the articles with professional content. Rights, policies, and cost containment were the major themes of the articles with administrative content.

Only one article was categorized as administrative in the decade of the sixties. The American Nurses' Association published in 1965, for the first time, Standards for Organized Nursing Services to serve as a guide for nursing departments in any clinical setting. The standards were intended to serve as a tool for the efficiency of the departments of nursing in organizational settings. These standards recognized nursing administration as being ethically responsible for the provisions of the best possible nursing care for patients under the most ideal working conditions for employees and for reasonable costs. ANA has revised these standards several times. The last revision was published in 1988.

There were three articles published in the 1970's which I categorized as administrative ethical concerns. One (Felton and Smith, 1972) was on policies and staffing for abortions, discussed previously. One was a news article

published in the November 1970 "News" section about a nursing leader and her address to the American Hospital Association in Houston, Texas, defending strikes for health care workers as an ethical mandate. Sometimes employment settings prevent the ability to give minimally accepted levels of nursing service. The ethical responsibility, then, is to inform the public about efforts to change employer practices. According to the article, there is an ethical responsibility to the patients and the public to strike to improve employment settings and the ability to give quality nursing care. The third article in July 1974 was an account of the author (Andrews) and a coworker allowing a patient to die after he arrested numerous times. He had advanced cancer of the lungs with metastases and had endured two weeks of heroic measures to keep him alive. That article discussed some of the ethical concerns regarding letting the patient die or the patient's right to self-determination. Some aspects of these concerns were discussed earlier in this chapter and used as examples to show the distinctions between the ethical concerns for the professional staff nurse, the private (Catholic) nursing administrator, the public administrator and the physician. For example, a physician might be inclined to continue to treat a dying patient; a public administrator might be

inclined to support the public interest and constitutional guarantees such as personal liberty; the Catholic administrator might be inclined to support the sanctity of life; and, the professional staff nurse might be inclined to support individual rights.

During the decade of the sixties, the technology to resuscitate and to sustain life by artificial means became widely available. Cardiopulmonary resuscitation on all dying patients was a common practice. Then health care personnel became concerned about prolonging the suffering of the terminally ill and dying, and they began to agree in some cases to walk slowly to the patient. That behavior produced guilt and the fear of litigation which prompted nurse administrators and hospital administrators to encourage physicians to write do-not-resuscitate (DNR) orders for such patients. That act at times brought the family and the patient into the planning. However, some physicians were reluctant to write such orders or to discuss the options with the patient or the family, so automatic resuscitation procedures continued.

Numerous well known arguments have been made regarding the issues of letting die or the right to refuse treatment. There is a tension between those who would prolong life and those who would precipitate death. Arguments are generally

based on the principles of autonomy, beneficence, nonmalificence, and justice. In the Andrews (1974) article it appears that the consequence of doing further harm by making the patient endure further pain, agony and suffering rather than good (his recovery was not possible) was the primary consideration for the nurses' decision to let the patient die.

Moral principles may conflict. For example, a nurse administrator may be concerned with justice which could temper patient autonomy if the patient's care (e.g., the need for extraordinary staff time or limited technological devices) unfairly deprives others of equitable access to an adequate level of care. Staff integrity is also a concern for the administrator. Staff nurses need to be provided with the ability to remain true to their moral beliefs. These issues will be discussed further in Chapter 5 in relation to the collective caring model.

One article in the sixties, one article in the seventies and three articles in the eighties addressed the issues surrounding the letting die or DNR decision-making processes, policies, procedures and consequences. The earliest article addressing this in AJN was in the "News" column in August 1969. The article reported on a multidisciplinary conference grappling with the moral issues

facing those who have increasingly sophisticated techniques available and must make life-and-death decisions about using them. At that conference, Dr. Ellis pointed out that the nurse's primary commitment is to the patient's care and safety. The Andrews article in 1974 was discussed previously. Huttman wrote an article in 1982 discussing options to policies or procedures directing "no code" problems. That author feels that there needs to be more public education. The public needs to know the options: that not all physicians will choose for them, that there is the possibility of mechanical maintenance of life, and that a respirator turned on is almost impossible to turn off.

A "News" article in April 1984 discussed the recommendation by Health and Human Services to use infant care review committees (ICRC) to help deal with the ethical concerns of Baby Doe cases. Another article (Weeks, Gleason and Reiser, 1989) encouraged the use of ethics committees to assist with ethical problems of withdrawing treatment or limiting technological support. The results of an ethics committee in Texas were discussed. That committee formulated 11 pages of ethical guidelines for withholding or withdrawing medical treatment. The thrust of that document was simple: The health care team has no duty to continue treatment if it is ineffective. In Texas, a patient or his

surrogate can direct the health care team to withdraw treatment or life-sustaining procedures in terminal illness. The ethics committee felt that it helped the staff withdraw intensive therapy and provide supportive care until death. Some nurses are angered and disillusioned when painful invasive treatments are inflicted on patients who cannot benefit from them. Disagreements between professionals can create discomfort. Disagreements occur around the balance of the benefits of advanced technology and its use. Help is needed to make sound decisions about the appropriate use of medical technology. Focus needs to change to positive prescriptions of care including pain relief, comfort measure and family support. Each situation needs careful evaluation of the patient's psychological status, hospital course, values, life style and beliefs about death and dying. The administrative concerns surrounding these issues involve policy making and implementation, staff support, shared decision making and public education (Weeks, Gleason and Reiser, 1989).

The remainder of the ethical articles with administrative themes in the eighties addressed the ethical issues surrounding scarce health care resources (including staff) and cost containment. Two articles stressed that it is the responsibility of nursing administration to solve

identified staffing problems. The problem can be either short staffing or incompetent staff. Cushing, (1986) suggested the use of a nurse-staffing committee to identify and correct staffing problems and to work closely with a professional care committee in developing nursing department policies and procedures. Another article written by Cushing in June 1987 again discussed the obligation of the nursing administrator to provide adequate staffing on specialized units as a duty owed to patients on those units.

Another article concerned with staffing problems was published in the "News" column of the January 1985 issue of AJN. That article presented the unfair dismissal of two nurses and one operating room technician. This unjust employment practice occurred after the staff refused to work in operating rooms with airborne black matter created by an apparent problem with the ventilating system. The Kansas Nurses' Association was collecting donations for their defense.

The allocation of scarce health care and nursing care (staff) is usually based on priorities and goals determined by standards, values, and political practices which may or may not pay attention to the principles of justice and equality. Sometimes cost containment or profit priorities rank higher than other more idealistic priorities.

Decisions may become more difficult even when trying to be just if there is not enough of the resource. Ethical decisions need to be based on balancing benefits against potential harms with a strong community or collective commitment. A model such as the collective caring model to be presented in Chapter 5 can be useful for such difficult ethical decision making.

The profit motive or cost containment concern was evident in several articles. One article in the "News" column in the April 1986 issue discussed a product-line strategy with an emphasis on annual profits and losses. Product-line management is not just a choice between mission or money. What's right for the patients is the basis for decisions. Early discharge was the topic of another article by Cushing in the April 1989 issue addressing cost containment. The physician and not the health care payer is responsible for determining the treatment and number of days needed to complete the treatment. The Erickson and Mitchell (1988) article discusses health care rationing. It was felt that fair criteria should be used in allocating resources and treatment such as pediatric liver transplants. The administration and the staff were careful to avoid the appearance that money, class, or race played a part in a nine-month-old being denied the opportunity for a liver

transplant.

This research project categorizing the ethical articles published in AJN throughout the century shows a definite distinction between personal, professional and administrative concerns throughout the century. It also correlates with the results of the historical research on the Code presented in Chapter Two. Early administrative concerns were improvement of the image of the profession with the enhancement of nursing education and training. The middle of the century focused on forming and implementing a Code and the war effort. Current ethical concerns can be correlated with scientific advances and modern technology as well as the recognition that nursing is autonomous and that nursing administration can make a difference.

There has been a shift in responsibility and accountability from the physicians and employer to the patient and the public. Administrative concerns regarding the acceptance of responsibility and the delegation of nursing activities appeared first in the 1960 Code. That issue correlates with the beginning of an emphasis on ethical concerns for nurse administrators as evidenced by articles published in AJN during this century.

Conclusion

This chapter has presented the argument that the role of the nursing administrator is unique and quite different from the nursing practitioner or the physician. Nursing and medicine have traditionally had different orientations, educations, functions, and socioeconomic status. They have radically different values and ethics, as evidenced in this chapter by using examples such as informed consent, letting die, cure versus care orientations and economic motives. The context and content of their respective ethical concerns and decisions are different.

That same argument is extended to present the distinctive nature of nursing administrators. The professional nurse and the nursing administrator have different orientations, boundaries, educations, functions and status. Therefore, they have different values and ethics as evidenced in this chapter by using examples such as informed consent, abortion and scarce resources (short staffing). The content and context of their respective ethical concerns and decisions are different.

This argument can also be extended to those nursing administrators employed in public versus private organizations, as evidenced in this chapter by using the examples of such issues as staffing for abortion units,

constitutional principles (e.g., religious freedom and personal liberty) and the public interest. Public administrators incur unique responsibilities and functions. Their administrative discretion needs to be guided by a concern for the public interest, public values, and constitutional principles as well as knowledge about the unique nature of public policy and public organizations.

These arguments have been supported by an historical perspective of hospitals and medicine, nursing statute and case law, health care policy, nursing administration, and nursing ethics. This historical analysis was further supported by an examination of ethical articles published in AJN throughout the century. These analyses focused on the trends which led to nursing autonomy and the present status of nursing administration. This historical perspective also provided the basis for the conclusion that nursing is distinctive from medicine and that nursing ethics are distinctive from medical ethics; that nursing administration is distinctive from nursing and that ethics for nursing administrators, especially for those employed in public organizations, is also distinctive.

Some of the unique concerns of nursing and nursing administrators were revealed in the research on the articles published throughout the century. The current concerns of

nursing administrators will be explored further in Chapter 4 and research on ethical articles published in administrative journals will be presented. That chapter will help illuminate the current status of nursing administrators and the validity of their ethics.

CHAPTER 4

Current Concerns

Chapter 3 provides a historical perspective of how nursing became autonomous and how nursing administration evolved. An argument is made and supported for the distinctive nature of ethics for nursing administrators, especially those employed as public administrators. Practical examples are used to illustrate the distinctions.

The current nature of ethics for nursing administrators is discussed in Chapter 4. Current concerns expressed in current research and literature are explored. An analysis of ethical articles published over the past 20 years in two leading administrative journals is presented. Conclusions are drawn about the major current ethical concerns for nursing administrators and an argument will be made that the current ethic for nursing administrators is invalid, especially those employed as public administrators.

The Role of the Nursing Administrator

Corwin's (1961) research paved the way for role research in the field of nursing and more recently nursing administration. Corwin identified three major types of role

conceptions that are held by nursing students, faculty, and licensed professional nurses. These include: (1) service role--oriented toward direct, human care of the client; (2) professional role--oriented toward the nursing profession; (3) bureaucratic role--oriented toward the organization and administration. Corwin believes that these three conceptions are held simultaneously, and in varying degrees. Minnehan (1977) supported this multi-dimensional nature of the role conceptions, rather than three distinct roles. Since Corwin's typology was developed, a vast amount of nursing research has been conducted which examines role concepts (e.g., role conflict and role deprivation) and the various sources of differing role conceptions. Two potential sources have been examined by the theorists as determinants of role conceptions: The individual's internal characteristics and the socialization process.

Using Corwin's role conceptions or role orientations, numerous nursing researchers (e.g., Brown, Swift and Oberman, 1981; Jones, 1976, 1977; Olesen and Davis, 1966; Simpson, 1967; Warner and Jones, 1981) found role conceptions were the result of a socialization process. However, others (e.g., Kinney, 1985; Joseph, 1985) found correlations between internal individual variables (e.g., masculinity- femininity; attitudes towards decision making)

and role conceptions.

Other nursing researchers (Brenner and Kramer, 1972; Kramer, 1968; Kramer and Baker, 1971; Pieta, 1976), building on Corwin's typology, studied role deprivation or role conflicts. Generally it was found that nurses identified with the professional role and had a conflict between the idealized professional nursing role and the bureaucratic role demands.

Morris, Steers, and Koch (1979) investigated the influence of organizational structure on role conflict and ambiguity. These researchers found that the lack of participation in decision-making (the perceived level of job-related discretion) within the organization was significantly related to role conflict for professional workers.

The field of nursing ethics has recently begun to build on Corwin's typology depicting conflicting loyalties. The values inherent in each of the different orientations are thought to influence the perceptions and behavior of the individual. A descriptive study by Ketefian (1985) tested the relationship between professional and bureaucratic role conceptions and moral behavior. The professional orientation was found to be positively related to moral behavior. Bureaucratic role discrepancy (the extent

to which the perception of the ideal role conception of nursing differs from the perception of the actual practice of the role) was also found to be positively related to moral behavior. This study contends that it is an oversimplification to view professionals in bureaucracies as either professionally or bureaucratically oriented.

A slightly different typology was used by Swider, McElmurry and Yarling (1985) who examined the priorities reflected in the decisions reported by 775 senior baccalaureate nursing students when presented a case depicting an ethical dilemma. Categories used in content analysis of responses were: (1) patient-centered responses, (2) physician-centered responses, and (3) bureaucracy-centered responses. Small groups of five students made 1,163 decisions of which 9% were patient centered, 19% were physician centered and 60% were bureaucracy centered.

Although some internal variables have been related to Corwin's typology, the majority of nursing theorists and researchers building on Corwin's ideas are subscribing to a socialization theory for determining an individual's value set or orientation that influences an individual's behavior or decision-making.

Research focusing on the role of the nursing

administrator has just begun to emerge in the last two decades (e.g., Arndt & Leager 1970; Stevens, 1981). Functions of the role were the variables studied in the early research projects. Simms, Price and Pfoutz (1985) also studied functions, but added that information management and cost containment are current concerns for nursing administrators. Those researchers also pointed out that nursing administrators are becoming more aware of public needs. For example, as America greys, care is needed to meet the special needs of the elderly.

Poulin's (1984) role research also showed a concern for society's needs in a cost-conscious environment. Poulin's results showed that nurse executives deal with complex patterns of interactional behaviors in an ever-evolving role.

The results of Sietsema and Spradley's (1987) study supports the contention in the literature (e.g., Fry, 1985; Silva, 1984; 1990) that there is an ethical component to the role of the nursing administrator. Sietsema and Spradley found a statistically significant association between the presence (or absence) of an institutional ethics committee and the executive's report of experiencing ethical conflicts between the professional and administrative roles. According to Sietsema and Spradley, the issues creating

ethical dilemmas for nursing administrators include: access to care, distribution of resources and the right to health and health care.

The literature supports the fact that nursing administrators have numerous responsibilities and functions. The word "administer" is a Latin word meaning "to serve". Nursing administrators serve many different collectives and in varied roles.

The ANA has updated the Standards for Organized Nursing Services (1988) which is compatible with the ANA Code. According to that document, nursing administrators are responsible for the management of nursing services and accountable for the environment in which nursing is practiced. Nursing administration ensures that policies are developed which are consistent with organizational goals and objectives. The nursing administrator contributes to long-range planning and day-to-day operations including: resource allocation, decision-making, organizational communication, coordination, staffing, personnel guidance and supervision, evaluation, planning and monitoring the budget, and research activities. In addition, the nursing administrators collaborate with other administrators and employees in organizational and community planning and programming (ANA, 1988).

Conflicting or Confusing Responsibility and Accountability

According to Batey and Lewis (1982), a responsibility is a charge or duty for which one is answerable (accountable). Clarity rarely exists regarding the distinct boundaries of responsibility and accountability. As demonstrated by the current literature and research, nursing administrators have a wide range of responsibilities. However, in an attempt to clarify or narrow the range, it can be said that nursing administrators are responsible for promoting, developing and maintaining a distinctive caring environment for nursing and nursing care in an organizational setting. That setting is usually a hospital.

At the beginning of the twentieth century, nearly all U.S. hospitals were independent (Wolper & Pena, 1987). However, after two world wars and a great depression, the number of governmentally controlled hospitals increased dramatically. Even with recent trends over the past few decades towards deinstitutionalizing psychiatric patients and privatizing the hospital industry, 31% of all hospitals were under government control in 1992; 18% were under proprietary control and 51% were under non-profit control (Statistical Abstract of the United States, 1994). Therefore, nursing administrators may, about one third of the time, be employed in governmentally controlled hospitals

as public administrators. As mentioned previously, "administer" means "to serve." As public administrators, nursing administrators serve the public and they are accountable to the public.

Batey and Lewis (1982) define accountability as the fulfillment of a formal obligation to disclose the principles, relationships, results, income and expenditures for which one has authority. Accountability as such is based on official mandates and requirements. The public mood or emphasis is currently on accountability (Levenstein, 1979). This is especially true with public organizations. Public organizations are scrutinized closely.

Ethical problems concerning what the literature (e.g., Brenner and Kramer, 1972; Corwin, 1961; Pieta, 1976) calls "conflicts of loyalties" or "conflicts regarding multiple accountabilities" arise when confusion exists regarding the priority of loyalties or accountabilities. As shown in previous chapters, nurses are held ethically and legally accountable for their actions. The 1985 ANA Code states "Neither physician's orders nor the employing agency's policies relieve the nurse of ethical or legal accountability for actions taken and judgments made". The revisions of the Code show a shift in the recognition of accountability from the physician and employer to the

patient. The nurse is a patient advocate and the nursing administrator is a public advocate. These accountabilities have been supported by statute and case law, as illustrated in Chapter 3.

However, the priority of accountabilities is not at all clear to the nurse or nurse administrator, as evidenced in the literature. A recent research project supports this contention. Batey and Lewis (1982) researched the concepts of responsibility, authority, autonomy and accountability by studying the literature and surveying directors of nursing service. These researchers stated that only two of the 12 directors of nursing service claimed they were accountable to patients and a few referred to the informal accountability to physicians. Most cited accountability to the hospital administrator, hospital board and the community or consumer group.

Moral Behavior and Moral Development

Role research and research regarding conflicts of loyalties are building on socialization theory to determine a value system or orientation that influences behavior. In contrast, another internal determining source (moral development) has been studied by Kohlberg, over the same twenty-year period as Corwin's role concepts, and is

currently popular among nursing researchers. Lawrence Kohlberg (1978) refined and validated a hierarchical scheme of moral development, which is both descriptive and prescriptive. Kohlberg's cognitive-development model has three levels: (1) the preconventional level, (2) the conventional level, and (3) the postconventional level. Parallelling those levels are six stages, two at each level. He wants people to develop to higher stages of moral development rather than to become fixated and frozen at a lower stage. Such an ethicist would be inclined to urge individuals to grow and develop their moral understanding and actions (Thompson and Thompson, 1985).

Currently, the moral reasoning and ethical behavior concepts of moral development theory are being used as major approaches to values education and research. Nurses basing their research on Kohlberg's theoretical framework include Chrisham (1981). Ketefian (1981, 1981), Mahon and Fowler (1979), Mayberry (1986), Munhall (1980), and Pinch (1985).

Both moral reasoning and moral behavior or practice are seen as important considerations by nursing researchers. Moral reasoning refers to thought processes and cognitive deliberations, while moral behavior consists of decisions made and actions taken (Ketefian, 1988). Ketefian (1988) critically reviewed the research focusing on these two

concepts of moral development theory in a National League for Nursing publication. She concluded that the relationship between education and moral reasoning remains ambiguous. However, critical thinking, intelligence, grade point average, and SAT scores were positively related to moral reasoning. The relationships between moral reasoning and moral behavior also remain unclear. Eighty-three percent of the studies reviewed found no relationship between the concepts, although the selected outcome criteria could create a relationship. Ketefian determined that selected organizational and work variables may predict some aspects of ethical practice, although the measures used on the whole lacked reliability and validity. For the most part, theoretically hypothesized relationships between the variables studied and moral reasoning or behavior were not supported.

It is not clear why numerous nursing researchers continue to use Kohlberg's moral development theory. However, nursing administrator research has not yet followed suit. Kohlberg's theory has drawn considerable criticism (e.g., Gilligan, 1977; Omery, 1983; Nokes, 1989) because Kohlberg studied male subjects. According to Omery's (1983) evaluation of dominant models of moral development, men and women vary in their moral development. Therefore, other

theories seem more appropriate for studying feminine roles. For example, Gilligan's feminine approach focuses on relationships and responsibilities to others as crucial ethical issues. Kohlberg's theory is construct oriented, while nursing is more context, or relationship oriented. Hopefully, nursing researchers in the future will be more selective in regard to choosing theoretical orientations for research.

Nonetheless, these models and related research present moral development as a progressive process, enhanced by education and experience. If that is so, then it can be concluded that nursing administrators have advanced due to their education and experience further than the traditional staff nurse. Staff would therefore learn from ethical rounds, committees or other collectives discussing ethical issues with nursing administrators.

Current Ethical Concerns

It is assumed that current concerns of nursing administration would be studied in research. The purposes of the national study conducted by Henry et al. (1987) were to determine: (1) a definition of nursing administration research and (2) priority nursing administration research questions. According to the most widely supported

definition given by respondents, nursing administration research is concerned with establishing cost of nursing care, examining the relationships between nursing services and quality patient care and reviewing problems of nursing service delivery within the broader context of policy analysis. An ethical issue identified in a scenario exercise as an additional priority was vulnerable populations and equity.

One of the objectives of Youell's (1986) research study was to describe, compare and contrast major ethical problems cited by nursing administrators. The problems identified concerned patients, nursing staff, physicians and the institution. The most difficult problems tended to be associated with nursing staff and with other professional relationships. The problems listed were similar to those noted in the literature, including problems related to resource allocation, technology, conflicting loyalties and values, staff relationships, conflicts between nursing staff and physicians and promoting quality of nursing care. The nursing administrator was perceived to have a role in conveying a caring attitude toward staff and patients, and expressing nursings' viewpoint to physicians and administrators, particularly on ethical matters (Youell, 1986).

To identify present and future ethical dilemmas in nursing administration, Silva (1987) mailed a questionnaire to 96 members of the Virginia Organization of Nurse Executives. Silva found that within the past five years, nurse executives were most involved with ethical dilemmas involving initiation of resuscitation or discontinuation of life-saving treatment and with informed consent. Within the next five years, nurse executives predicted the ethical dilemma most likely to affect them would be the allocation of scarce resources.

An Analysis of Published Current Ethical Concerns

The author of this dissertation did an analysis of ethical articles published in two leading administrative journals in an attempt to illuminate and classify the current ethical concerns of nursing administrators. The Journal of Nursing Administration (JONA) and Supervisor Nurse, now Nursing Management after a name change, have both been continuously published since 1970, a longer time than any of the other administrative nursing journals. All of the ethical articles published were identified by a hand search and cross-checked with the periodical's indexes. The articles were then classified, according to the main focus of the article as having either personal, professional or

practice acts and collective bargaining. Administrative concerns included: The role of the nursing administrator, collective bargaining, unjust dismissal, reassignments due to conscientious refusal, whistle blowing, patients' advocacy, no-code policies, value conflicts, confidentiality, and scarce resources.

From 1980 through 1989, Nursing Management published 70 ethical articles. Forty-five had professional content, while 25 had administrative content. Professional concerns included: whistle blowing, truth telling, patient's rights, patient advocacy, values, professionalism, death and dying, prolonging life, quality assurance, nurses' rights, organ transplants, informed consent and professional obligations to the public. Administrative concerns included: scarce resources, whistle blowing, health care policy, collective bargaining, quality assurance and credentials, as well as ethical rounds and ethical conferences.

The total number of ethical articles published in both journals over the past twenty years was 141. Of those, I classified 82 as having professional content and 59 had administrative content. I determined the content of each article to be mutually exclusive so that it was listed in only one classification. Therefore, I conclude that this analysis as well as other research and literature on ethical

issues illuminates the current ethical concerns of nursing administrators. Those concerns include: scarce resources, whistle blowing, staffing, collective bargaining, quality assurance, confidentiality, informed consent, no-code policies, and other policy issues.

Nursing Administration and Health Care Policy

The 1976 and 1985 Code emphasize nurses' expanded responsibility and accountability to act not only as patient advocates, but public advocates as well. The content of six of the tenets of the ANA Code have basically remained the same throughout numerous revisions. Therefore, I conclude that they represent lasting and enduring values of the nursing profession. The content of two of those tenets refers to public advocacy: (1) protect the patients and the public against unethical or illegal practices and (2) promote efforts to meet the health needs of the public.

Nursing administrators have ethical responsibility individually and as a collective to participate actively with the public and other health care providers to promote health care needs. Numerous nursing authors (e.g., Aroskar, 1987; Benoliel & Packard, 1986; Davis, Oakly & Sochalski, 1982; Holleran, 1985; McLemore, 1980) have encouraged nursing administrators to become knowledgeable about the

policy process and to expand nursing's role in the policy-making process in order to increase the profession's effectiveness in competing for scarce resources. The allocation of national health care resources toward cure or care is determined by policy established by administrative, legislative and judicial bodies of government or decision making in organizations. Policy guides objectives and power guides policy. Involvement in health care policy is a tool that is largely unused by nurses (Benoliel & Packard, 1986). According to that author, women are often uncomfortable with the use of power in leadership roles. Another reason may be that decisions made at the policy level may require decisions that value the common good over individual choice and autonomy.

Research in the area of nursing administration and policy is just beginning to emerge. Archer and Gochner's (1981) study identifies and evaluates political tactics nursing administrators have used and suggests ways to become more effective in political processes. Voting, writing to legislators and involvement in local political activities were the activities respondents engaged in the most often. Ninety-four percent felt that nurses are not as politically active as they should be. The reasons given for lack of political participation were: lack of preparation (28%),

apathy (24%), and failure to realize the importance of political participation (22%). Suggestions to encourage political participation included: posting and circulating information, education regarding issues, giving compensatory or released time for participation, role modeling and staff discussions.

Numerous authors have begun to acknowledge the link between participation in health care policy-making and ethics (Aroskar, 1987; Cowart & Allen, 1981; MacPherson, 1987). Nursing administrators have an ethical responsibility to encourage a more just distribution of health care resources according to public need and public interest. The public's interest or dominant public values need to significantly influence health care policy.

The Public Advocate and the Public Interest

Chapter 3 presents and supports the argument that the role of the nursing administrator is unique, especially those employed in public organizations which are also unique. The public interest is one of the concepts that makes public organizations, public policy and public administration distinctive. Numerous definitions of the public interest by various theorists are presented to show the primary significance of that idea as a guiding

principle. The contention that the nursing administrator as a public administrator or public advocate should promote the common good (i.e., public health) and respond to public values (i.e., the public interest) and constitutional principles follows from relevant facts presented in chapter 3. The discretionary power of the nursing administrator to formulate, implement and evaluate policy should be used to favor policies and an organizational climate supporting the public interest. Examples are developed in chapter 3 to show how public input (i.e., public interest) is used to develop local health care policies.

The concept of the public interest should be useful to the nursing administrator as a standard for public advocacy, public policy and organizational climates in public organizations. The concept of the public interest is covered in this chapter as a way to represent public values and clarify current ethical concerns for nursing administrators in the role of the public advocate. Public values have the potential to influence health care policies if they are represented in ethical decision making circles. Nursing administrators have an ethical responsibility to encourage a more just distribution of health care resources according to the public interest and public needs. Whether that happens or not may depend on the nursing administrator

in the role of the public advocate. The public interest is both a beginning and an end for health care policy which is the result of accommodations and compromise between the public interest, powerful interest groups (e.g., AMA, AHA) and political bodies.

One way to move toward the consideration of the values of society has been suggested by Rohr (1982). He states that public administrators need to transcend both personal and professional goals to respond to the values of the people in whose name they govern. The responsible public administrator has an ethical obligation to make discretionary decisions based on the values of society. In a society beset with diverse and multiple special interests, the public interest needs to be the controlling principle. The public interest is evident in the U.S. Constitution, policy, case law, statute law, political speeches, major Supreme Court decisions, scholarly interpretations of American history, religious sermons and many other sources (Rohr, 1978). Sources used for this dissertation to reflect the dominant values of society or the public interest include: the U.S. Constitution, the Code, case and statute law, historical trends and professional research and literature.

The growing public concern with health care is seen as a

positive trend with positive results by this author. This trend has had the effect of creating patients more willing to be part of the ethical decision making process (Silva & Zeccolo, 1986). Further evidence of this can be seen in the hospice movement and living wills. The idea that the public should be informed about alternative treatments and involved in ethical decision making about health care was unheard of at the beginning of the century. Social trends (e.g., escalating health care costs, the greying of America and technological advances) have increased public demand and public awareness of current ethical concerns. The media also keeps the public informed about current ethical dilemmas. Nursing administrators as public advocates have an ethical responsibility to represent the public interest in ethical decision making. Therefore, the nursing administrator needs to be current regarding public values and needs to watch the trends of health care as presented in the above sources.

The nursing administrator employed as a public administrator takes an oath to uphold the Constitution of the United States. One influence the Constitution has is to guarantee individual rights and limit government power which might encroach on those rights. In this sense, the nursing administrator as a public administrator is morally bound to

be a public advocate and to defend public rights. The Constitution's Bill of Rights safe-guards the public's rights to self-determination and freedom of choice. The public must be protected from the encroachment of powerful interest groups or unlimited government power.

Public administrators are also policy makers at their level of employment. Public policy is the unique output of public administrators. Public administrators analyze higher-level policies and modify them to the current situations and local levels, using administrative discretion. Therefore, public administrators need to accept the responsibility and accountability for their discretion and implementation of those policies. That discretion needs to be consistent with the public interest.

Tasks of the nursing administrator include making judgments about public priorities. Government (e.g., elected officials and public administrators) represent society and in this case nursing administrators need to represent the public and public values. For example, one of the tenets of the ANA Code that has endured numerous revisions is a guideline regarding respecting human dignity without prejudice. It can be assumed that this lasting and enduring value represents the public interest. Therefore, one responsibility of the nursing administrator would be to

ensure that all groups of patients be treated equally regardless of race, sex, political affiliation, disability, age or social status. However, the ethical issue of equality leads to the question of equity. The notion of equity may require unequal treatment in some cases. Some groups of patients (e.g., severely disabled newborns, the mentally retarded or emotionally disturbed, or prisoners) require additional (unequal) protection in order to ensure justice and prevent conscious or unconscious encroachment by health care providers who may be more interested in their own self-interest (e.g., research) than in equality or equity.

It is extremely important for nursing administrators to be aware of the public interest when using administrative discretion in implementing policies regarding vulnerable patient populations. Even local policies have the potential to affect our national health care system well into the future.

Conclusion and Interpretations

The literature and research regarding the role of the nursing administrator has offered considerable insight into the current nature of ethics for nursing administrators. Although nursing administrators have numerous and varied

functions and responsibilities, there is some consistency. For example, ANA's (1988) Standard for Organized Nursing Services is useful for clarifying the accepted functions and responsibilities of the nursing administrator. Recently, research has begun to address the responsibility of the nursing administrator to be aware of the needs of the public (Poulin, 1984; Simms, Price & Pfoutz, 1985; Sietsema & Spradley, 1987). In addition, nursing authors have identified that there is an ethical component to nursing administration (e.g., Fry, 1985; Sietsema & Spradley; Silva 1984, 1990).

Current literature and research, as well as the analyses conducted by the author of this dissertation, have helped elucidate the current ethical concerns of nursing administrators. Those concerns can be incorporated under the following headings: resource allocation, professional relationship problems, personnel problems, health care policies, rights, and responsibility and accountability.

There is an overriding concern in the research and literature (Brenner and Kramer, 1972; Corwin, 1961; Pieta, 1976; Poulin, 1984; Glennon, 1985) about conflicting loyalties or accountabilities. This may be confusion regarding the prioritization of accountabilities. However, it is unclear why this confusion exists. The analysis of

the Code presented in Chapter 2 clearly shows that the nurse is a patient advocate and is accountable to the patient. In addition, two of the six tenets that have existed throughout all of the revisions of the Code refer to: (1) protecting the patient and the public against unethical or illegal practices, and (2) promoting efforts to meet the health needs of the public. All of the current ethical concerns of nursing administrators identified in this dissertation could be classified under one of those tenets, either protecting the public or promoting the health needs of the public. Also, the trends in statute and case law presented in Chapter 3 recognize that the nurse is autonomous and is a patient advocate and the nursing administrator is a public advocate.

There may be several possible interpretations of this confusion regarding accountability. Nursing administrators are predominantly female and are socialized into the subservience and dependence of that role. Statute and case law recognizing the independent and autonomous identity of the nurse may not be fully accepted. Perhaps the norms at the beginning of the century stressing accountability to the physician and the hospital still exist.

To enhance and encourage the acceptance of the concept of public accountability, an educational emphasis is needed.

In-service education and classroom presentations regarding a historical evolution of the profession's responsibilities and accountabilities can be a start. Group discussions in ethical conferences and ethical rounds would also raise consciousness that confusion exists.

Another possible answer for the confusion in regard to accountability is the fact that nursing administrators were originally socialized into the individual patient care ethic of the professional staff nurse, emphasizing individual patient care and individual patient advocacy. That ethic is inappropriate for the nursing administrator who needs to be concerned with collectives of patients or the public. Perhaps the issue of accountability is confusing if the administrator has not converted patient advocacy to public advocacy.

The distinctions between the role of the nurse and the nursing administrator need to be made clear in the basic educational programs. Such knowledge would be useful to both the nurse and the administrator for preventing misunderstandings regarding responsibilities and accountabilities and for promoting productive working relationships. Common and distinctive values and concerns of the two roles need to be acknowledged and shared, again to enhance relationships.

Another possible contributing factor to the confusion regarding accountability for the nursing administrator may be that the two tenets of the Code stressing public advocacy have not been emphasized in education, literature or research. Nursing Administrators may feel that the Code is more for the individual professional nurse and has little to offer as a guide for nursing administrators.

These issues need to be addressed further in discussion and research. Nursing administrators need to begin to focus on the distinctive values and concerns of the profession and to think about useful ethical guidelines for that particular profession. Again, the individual patient care ethic of the professional nurse is not useful, valid or appropriate for the nursing administrator.

Another prevailing concern in the literature and research addresses nursing administration and policy making. Nursing administrators have been reluctant to enter into health care policy making. Again, this may be explained by the fact that females are reluctant to be in positions of power or decision making. Another explanation may be that as individual professional nurses they learned to follow and to value rules and regulations. Nursing administrators may feel uncomfortable with decision-making about collectives that involves a more utilitarian way of decision making

which values the common good over individual autonomy. Again the traditional nursing ethic does not serve the nursing administrator.

Another possible contributing factor to the nursing administrator's reluctance to become involved in policy making may be the fact that nursing administrators employed in public organizations have not acknowledged that they are public administrators. Public administration, public organizations and the public interests are concepts that need to be covered in educational programs for the nursing administrator. Nursing administration can use the role of the public administrator to reduce confusion regarding accountability and to help motivate administrators to become involved in policy-making. As public administrators, nursing administrators need to accept responsibility for analyzing and making policy. They are in a unique position to shape health care and need to take advantage of that position as public advocates. Again, the nursing administrator needs an ethic that will provide guidance for her as a public administrator and public advocate. The traditional nursing ethic just will not do. Recommendations to help alleviate this will be presented as The Collective Caring Model in Chapter 5.

In sum, usually when there is a conflict or confusion

between alternatives, that choice is influenced by value sets. However, sometimes there is even confusion regarding value sets. It is the contention of this author that this is the case with nursing administration. Nursing administrators continue to be influenced by the traditional nursing ethic which is inappropriate as a guide for nursing administrators. An ethical guideline for a profession needs to be closely related to the distinctive nature of that profession. Nursing administration is quite distinctive. It is a predominantly female, caring profession concerned with decision making in collectives about collectives. This involves a complex system of relationships.

Chapter 4 has reviewed the current nursing administration literature and research and extracted the current ethical concerns for nursing administration. Conclusions about those concerns were used as an interpretation arguing that the current ethic for nursing administrators is invalid. Recommendations were made in regard to specific concerns. A proposed ethic for nursing administrators is presented in Chapter 5.

CHAPTER 5

Collective Caring

Chapter 4 discusses the current nature of ethics for nursing administrators. That chapter also presents an analysis of articles with ethical themes published in two nursing administration journals which illuminates current ethical concerns. Those ethical concerns, health care policy, public administration and the concept of the public interest are discussed by the author of this dissertation to support the argument that the current traditional ethic for nurses is inappropriate for nursing administrators, especially those employed in public organizations.

Recently, nursing research has begun to address the responsibility of nursing administration to be aware of the needs of the public (Poulin, 1984; Simms, Price & Pfoutz, 1985; Sietsema & Spradley, 1987). In addition, two of the six tenets of the ANA Code that have existed throughout all the revisions refer to: (1) protecting the patient and the public against unethical or illegal practices and (2) promoting efforts to meet the health needs of the public. All of the current ethical concerns of nursing administration identified in this dissertation could be

classified under one of the two enduring tenets, either protecting the public or promoting the health needs of the public. The nursing administrator needs an ethic that will guide her as a public administrator and a public advocate.

A summary of the major points of this dissertation introduces Chapter 5. This summary substantiates the claim that the current ethic for nursing administration is invalid. A proposed ethical framework for nursing administrators, entitled "Collective Caring," is then presented and defended. Nurse administrators need to convert their previous ethic of individual patient advocacy, patient autonomy and patient well-being to a collective level of public advocacy, public autonomy and public health. Their administrative processes need to be concerned with groups rather than individuals. Relationships between and with groups (collectives) become paramount. The Collective Caring Model focuses on collective or group relationships and the nursing administrators' responsibilities to collectives. This is a more appropriate ethic, especially for those administrators employed as public administrators and responsible for promoting, developing, and maintaining a caring environment in an organizational setting.

Summary

The nature, origin and validity of ethics for nursing administrators are explored throughout this dissertation. A historical development of the Code for Nurses is presented in Chapter 2. An analysis of the revisions of the Code and the current Code is used to reveal the collective values of the nursing profession. The most recent (1985) revision of the Code emphasizes patients' rights (e.g., self-determination and confidentiality) and the nurse's obligations to the patient and the public, as opposed to the physician or employer (See appendix G). The 1985 ANA Code states, "Neither physician's orders nor the employing agency's policies relieve the nurse of ethical or legal accountability for actions taken and judgements made." This dissertation argues and uses research and literature as well as statute and case law to support the notion that nurses and nurse administrators are held ethically and legally accountable for their actions.

The 1985 Preamble of the Code lists for the first time the universal moral principle of respect for persons and the principles (e.g., autonomy, beneficence, nonfeasance, veracity, confidentiality, fidelity, and justice) which, along with consequential considerations, act as bases for ethical decision-making by nurses. Each revision of the

Code reflected progressive professional autonomy. Six tenets of the Code remained essentially the same throughout the revisions: (1) maintaining professional competence; (2) maintaining confidentiality; (3) respecting human dignity without prejudice; (4) practicing ethically in regard to advertisement; (5) protecting the patients and the public against unethical and illegal practices; and (6) promoting efforts to meet the health needs of the public. The last two focus on collective action to protect the public.

In Chapter 3, historical trends over the twentieth century provide a basis for understanding how nursing became autonomous and how nursing administrators evolved from early teachers to administrators of nursing service. An argument is made that nursing administrators are distinctive and so are the ethics for nursing administrators, especially those employed as public administrators in public organizations. With an escalation of federal involvement in health care and escalating health-care costs, there are more regulations and constraints on health care. This author predicts that there will be more governmental involvement, more legislation and more regulation, as evidenced by recent attempts to develop a national health care program. More public concern and interest is also anticipated. The public will become more and more interested in health in an attempt to avoid the

high cost of disease.

An analysis of articles with ethical themes presented in Chapters 3 and 4 indicates that the nursing administrator's ethical concerns include: rights, health care policies, organizational policies, staff incompetency, staff shortages, collective bargaining, quality assurance and credentialling, cost containment and scarce resources, informed consent, institutional whistle-blowing, ethical rounds, conferences and ethical committees. These all involve collectives of staff and patients along with policy decisions designed to deal with concerns of collectives of staff or patients.

Chapter 4 gives a clear picture of the current nature of ethics for nursing administrators. Current literature, research and meaningful concepts relevant for this dissertation and the nursing administrator role are presented. That literature shows that the most difficult ethical problems for nursing administrators tend to be associated with nursing staff and other professional relationships (e.g., scarce resource allocation, conflict resolution, and nursing service delivery). The nursing administrator is perceived to have a role in conveying a caring attitude toward staff and patients and in expressing the nursing profession's viewpoint to physicians and

administrators, particularly on ethical matters (Youell, 1986). That chapter concludes with a clear statement that the traditional ethic for the individual professional nurse is inappropriate for the nursing administrator. The professional nurse is concerned with individuals and the nursing administrator is concerned with collectives. The nurse administrator has an ethical responsibility to participate actively with the public and other health care providers to promote health care needs. One reason nurse administrators may feel uncomfortable at the policy level may be that decisions at the policy level require decisions that balance the common good with individual choice and autonomy. Nurse administrators have an ethical responsibility to encourage a more just distribution of health care resources according to public need and public interest. Dominant public values need to significantly influence health care policy.

A more appropriate base for ethical decision-making for nursing administrators is presented here in Chapter 5. This model is entitled "collective caring" and consists of three major concepts: caring, cooperation and collective relationships. In the complex health care system, the nursing administrator functions in a matrix of relationships that have ethical dimensions. Collective caring is an

interplay between those relationships and caring. An ethic for nursing administrators needs to be closely related to the values of the profession (i.e., caring) and the values of collectives (i.e., nursing staff, the public interest and physicians).

The three major concepts of the Collective Caring Model (caring, cooperation and collectives) are defended in the literature and by this author as appropriate for nursing administration. Collective Caring as a process model involves choosing (a cognitive component), enhanced by caring, cooperative and collective considerations, as well as utilitarian outcomes as goals for the whole system (e.g., the hospital organization). The choice results in increased happiness or utility for the collectives and involves acting (a behavioral component) personally and professionally to resolve conflict. Such a utilitarian view could create a common goal for the various collectives and prevent the sacrifice of smaller, conflicting goals of various collectives. Utilitarian considerations could also provide creative outcomes in an attempt to depersonalize conflicts between the collectives. The nursing administrator can evaluate the process and outcomes by affirming the choice publicly (the red face test) and evaluating the possibility of repeating the choice consistently in similar situations.

There are various methods used to decide what is right or wrong. Those methods distinguish one ethical theory from another. Within normative ethics, there are two major theories: deontology and utilitarianism. Both theories employ rules differently and utilitarianism considers the consequences of an act in determining right or wrong. It is argued here that deontology may be useful to the traditional nurse working with individual patients. However, that theory is not as useful as utilitarianism for ethical decision making by the nursing administrator. Nursing administrators need to convert the ethic of individual patient advocacy, patient autonomy and patient well-being to a collective level of public advocacy, public autonomy, and public health.

Deontology uses principles or their derivative rules to guide ethical decision making. Deontological ethics looks at the intrinsic quality of the action itself or conformity to a rule as the determinate of what is right or wrong, irrespective of the consequences the rule may produce in a particular situation. For example, nonconformity to respecting a patient's confidentiality would be intrinsically wrong. Principles are derived from universal values and act as guides for action or behavior. This system would be useful for the traditional nurse

because the principles remain the same in diverse settings and circumstances. The situation or the consequences would not need to be considered. However, when rules or principles conflict or harmful consequences are evident deontology is not a perfect solution (Parsons and Parsons, 1992). This is often the case with nursing administrators who work with collectives of diverse professionals with different ethical rules that can and do conflict.

Utilitarians, on the other hand, assert that the right action is the one that produces the greatest amount of pleasure or happiness over pain. Bentham, an influential utilitarian sensitive to social issues, determined that pleasure was to be understood or measured in terms of utility, especially social utility (Fowler and Levine-Aruff, 1987). Later, this was termed the utility principle. For all utilitarians, the utility principle is the ultimate appeal for determining whether actions are right or wrong. However, controversy has arisen whether the principle should be applied to particular acts (act utilitarianism) or to rules of conduct (rule utilitarianism). According to the rule utilitarian, actions are justified by rules such as the principle of veracity. These rules in turn are justified by the appeal to the principle of utility. Generally following sets of rules provides the necessary background for society

by maximizing social utility. Rules (e.g., the principle of veracity) condemn actions (e.g., lying), but under some circumstances lying may be justified and have overriding utility (Aiken and Catalano, 1994).

With act utilitarianism, the particular situation determines the rightness or wrongness of a particular act. An act is good when it promotes pleasure and wrong when it promotes displeasure. Although pleasure is the pleasure of the greatest number of people, the pleasure of each person weighs equally (Aiken and Catalano, 1994).

The utilitarian can justify almost any decision upon the principle of utility. It fits well in our society and uses rules only as needed guides to benefit the greatest number. However, as mentioned previously it is difficult to measure the greatest good for the greatest number and controversy exists about the principle of the "end justifies the means." Some see utilitarianism as arbitrary and self centered. Therefore, it is often combined with other types of decision making, as in the case here with the Collective Caring Model.

The Collective Caring Model integrates utilitarian perspectives into the process of ethical decision making for nursing administrators. That process, as conceptualized and presented by this author consists of three steps: choosing,

acting and evaluating. Utilitarianism would enhance all three steps. The principles of utilitarianism would clarify the values of the different collectives and convert them into a collective value or goal of the greatest good for the greatest number. It is generally agreed that values can serve as principles of goals. That can help unite the factions, depersonalize differences, contribute to creative outcomes, and help focus on the situation. This clarification of the values of the various collectives involved in an ethical issue and the resultant use of those values as standards, goals or rules for ethical decision making has been generally slighted by ethical theory or ethical decision making models. Collective values should be used as goals and end-state consequences desired and should be important for prioritizing alternatives. Utilitarianism would enhance the second step (acting) by clarifying the actions toward a common value or goal. The third step (evaluating) also would be assisted by utilitarian perspectives. The results would be measured or evaluated by the utility principle or the desired consequence. When scarce resources mean denying service to a particular individual or group, a decision based on doing the most good for the greatest number is a defensible position. The resultant decision (the product) and the process could be

evaluated by affirming the trends in public values or the public interest. This step of evaluating would hold the nursing administrator accountable or answerable for their ethical decisions to the public. For example, as patient autonomy has become the norm, public demands for less medical interference with the process of dying has also grown. Nursing administrators need to accept this public input and use it to design organizational policies to reflect the trend in the public interest to assure those values. The nursing administrator has an obligation to align policy with the public interest. That alignment can and should be verified or evaluated. Finally, utilitarianism and the Collective Caring Model should contribute to the consistency of decisions benefiting the greatest number.

Utilitarianism is appropriate for ethical decision making for nursing administrators who are concerned with collectives of professionals and the public. A reasoned accounting of the situation can be made and ethical decisions can be justified using the underlying principle of "the greatest good for the greatest number." For example, actions such as whistleblowing can be defended using the utility principle. The public interest, discussed previously can be seen as enduring values or beliefs that a

certain action or condition is desirable as an end-state. Utilitarian theory allows the use of the public interest as a guiding principle for ethical decision making by nursing administrators employed as public administrators in public organizations and as a criterion for evaluating the decision (the product) and the process.

Hospitals, as organizations, appear to have a utilitarian value system (Purtilo and Cassel, 1981). They are oriented toward providing the greatest good for the greatest number. Deontological (rules) or individual rights are often slighted for utilitarian considerations of efficiency and effectiveness. For example, collective bargaining is one of the current ethical concerns of nursing administrators. Nursing administration has an obligation to provide adequate staffing for patient care. However, if understaffing is a chronic problem, patient care suffers. Providing quality patient care is often slighted in favor of providing more care for less money. A strike may not always be necessary. If the Collective Caring Model or process is used, a utilitarian perspective (providing the greatest good for the greatest number) would be integrated with the concepts of caring, cooperation and collectives. Nurse administrators could encourage a cooperative attitude and engage the groups in a dialogue. The end result could be increased utility or

happiness for all collectives (staff, patients, and administration) involved in resolving the conflict in a cooperative manner. These major concepts of the Collective Caring Model need further clarification.

Caring

Nursing has often been referred to as a science of caring, and caring has been identified as the essence of nursing practice and the traditional ideology of nursing. The caring component of nursing has been developed into an ethic by numerous authors (e.g., Benner, 1984; Benner & Wrubel, 1989; Leininger, 1984; Noddings, 1984; Ray, 1987; Watson & Ray, 1988). If caring is central to nursing, then nurse administrators would also view the concept as central to their unique function in organizations (Leininger, 1984). For example, the goal of nurse administrators is to provide a caring environment in an organizational setting for collectives of nurses and nursing care for collectives of patients.

Benner, et al. (1986) presented the concept of care as an essential component of the domain of nursing, as well as different perspectives about care in relation to nursing service administration. Miller (1986) in that same symposium and article presented the care concept as a basis

for nursing administration and encouraged nursing administrators to recognize, maintain, study and enhance the caring concept.

In a study done by Teresa Cervantez Thompson (1986) published in the Journal of Nursing Administration, care was seen as an important part of the nurse administrator's thought and action. All of the respondents identified care as part of their roles in relationships with their staff. Those nurse administrators studied were working toward making care an explicit part of their profession and administrative responsibilities.

In fact, a caring ethic for nursing administrators seems more appropriate than a management model or the traditional nursing ethic emphasizing patient advocacy or individual patient care, because nursing administration needs to be grounded in a concept central to that unique domain. Identification with caring would assist nursing administrators to resist threats to caring in management roles (Miller, 1987). Clatterbuck and Proulx (1981) and Christensen (1988) have developed ethical frameworks for nursing administration based on management models. Christensen applied nursing concepts and general ethics to administrative practice as a basis for creating an ethical work environment for nurses. The focus was on the work

environment and management. Clatterbuck and Proulx (1981) explored the ethical base of nursing economics and accountability, focusing on nursing management and the ethical exercise of power. Staffing and budgeting were the main ethical concerns. Both models neglected the centrality of caring.

Caring, as a feminine ethic grounded in relationships, seems to be an appropriate base for a value system of a profession made up predominantly of females in feminine roles. However, feminine in Gilligan's (1977) sense does not mean for use only by females; males also have feminine values. Her feminine approach focuses on relationships and responsibilities to others as crucial ethical issues. This Collective Caring Model focuses on collective or group relationships and responsibilities to collectives. Carol Gilligan (1977) maintains that women define themselves in a context of relationships and judge themselves in terms of their ability to care. The justifications for actions that females usually give, point to feelings, needs, situational conditions, and their own ideals rather than more masculine justifications of universal principles, reasoning and judgment (Gilligan, 1977). Males or females could use either feminine or masculine justifications or value systems.

An ethic of caring redefines Kohlberg's developmental model. Lawrence Kohlberg's (1975) theory presents a hierarchical or quantitative description of moral reasoning. According to Kohlberg, females do not progress to the highest level. If a progressive process does occur in moral development, then it can be concluded that nurse administrators have developed due to their advanced education and experience. Staff could therefore also progress with collective sharing and learning (e.g., ethical rounds, ethical committees and staff meetings) while discussing ethical issues.

Noddings (1984), sees the feminine approach to moral reasoning as being founded in caring and those individuals see themselves as "good." A difference exists between one who chooses to be good and one who is thought of as good. If one chooses to be good, one is able to progress to the highest level of moral reasoning, according to Noddings. That author refers to the ethic of caring as a "feminine" ethic, in the sense that caring is more feminine than a rational (masculine) orientation. For example, Kohlberg's theory is more construct oriented, while nursing and this Collective Caring Model is more context or relationship oriented. Both Gilligan's and Noddings' caring is developed and supported through contextually-based relationships. The

ethic of caring does not replace individual rights. Rights and caring reflect "the fundamental tension in human psychology between the experience of separation and the experience of connection," at least according to Gilligan (1977). Caring is relationship-oriented, not rule-oriented (Gilligan, 1977; Noddings, 1984).

An ethic built on caring would not be a duty to care but a value to care. Caring will provide a normative standard which in turn will provide identity, meaning, and guidance for nursing administrators. Caring is an appropriate ethic for nursing administrators who do not do hands-on nursing care because caring does not assume illness or injury. One can care for wellness and health (Watson and Ray, 1988).

According to Noddings (1984), caring is not situational ethics or consequential, but locates morality in the pre-act consciousness of caring. Yet it is not a form of agapism or Christian ethics. That author stresses human love or human caring is quite enough on which to found an ethic (Noddings, 1984).

The Collective Caring Model presented here builds on Gilligan (1977) and Noddings (1984) caring, but adds the idea of collective caring in a more utilitarian sense with situational considerations. Collective Caring as a process involves choosing (a cognitive component), enhanced by

caring, cooperative and collective considerations, as well as a utilitarian perspective. A utilitarian ethic or view could create common goals for the whole organization and diffuse conflict created by smaller collectives sacrificing individual goals. The choice results in increased happiness or utility for the collectives and involves acting (a behavior component) personally and professionally to resolve conflict. Collective Caring encourages caring relationships with collectives (committees, staff, groups) for collectives (staff, groups, the public). This does require a more utilitarian perspective than the traditional staff nurse might use during the decision making processes.

In addition, this approach utilizes situational ethics. Parsons and Parsons (1992) define situational ethics as the ethical decision making process that includes consideration of the circumstances of the situation, as well as fundamental ethical principles. Using such an approach, some people choose to evaluate the outcome of the decision (a utilitarian ethic) to determine if the end justifies the means. The alternative with the greatest social benefit is chosen after an analysis of the social costs and benefits (Parsons and Parsons, 1992). To consider the situation and the outcomes paves the way for cooperative behaviors by the different collectives in the situation.

Caring and Cooperation

Conflicts occur between collectives in the health care system because different groups usually have different value systems and priorities, as stressed in Chapter 3. More than 70 years ago, Mary Parker Follett (1924), an important female theorist, was influential in generating a more human rather than scientific approach to management and administration. She suggested that the way to resolve conflict in organizations was to discover the law of the situation and obey it. She wanted a focus on the current situation. In doing so she turned away from the classical management model that relied on a hierarchial governing by rules, regulations and orders to a model encouraging cooperation between groups. Follett stressed integrating opposing points of view of various groups for better control of the whole situation or organization.

Mary Parker Follett wanted a science of cooperation or integration, not merely good intentions or kind feelings, but based on a successful process or methodology of cooperation (Metcalf, 1926). Cooperation, according to Follett, needs to be learned. She suggested that administrators systematically record concerns for reference by future administrators. Similar situations could be studied from records. In addition, she saw a need to

prevent internal conflicts between groups by uniting or integrating the concerns of different groups, thus depersonalizing or repersonalizing the situation. According to Follett, all those concerned need to study the law of the situation and obey it to create the desired attitude for cooperative study and decision making (Metcalf, 1926).

Mary Parker Follett was one of the first writers to perceive interrelationships between behavioral and holistic (systems) perspectives of organizational activity (Parker, 1984). She saw groups as having the ability to control themselves (behavioral) by studying the whole situation of the organization, including the environment. The collective will was to evolve through the group process of ideas, feedback and reciprocity of action. There was a sharing component between groups and through the group process. Thus differences would be continuously brought out and integrated into the collective thought and will. Follett's goal was unity and she was concerned with integrating organizational activities into a whole. The integration of opposing or differing ideas or ideals were intended to achieve more than compromising and sacrificing to continue previous operations. Mary Parker Follett allowed the contribution and addition of differing points of view to move in new directions. Integration was intended as a

process, for conflict resolution and cooperation. That process concentrated on the interrelationships of the various groups towards collective self-control (Parker, 1984).

Follett's (1924) ideas were in contrast to scientific or classical management theory, with individual workers and smaller groups having norms and rules imposed on them through the hierarchy or by outsiders. Follett's (1924) law of the situation, integration and cooperation could serve contemporary theorists well and are components of the Collective Caring Model presented here. Follett focused on the sharing of thinking and ideas that occur when people work in groups. She believed groups who communicate with each other begin to think in a more compatible and harmonious way. In addition, she stressed that it is the role of the administrator to cultivate group interaction and to improve relationships. Follett's concepts of the law of the situation, cooperation and integration contributed to later contingency theories of leadership, power, and organization design. If the collectives can share and accept their differences, then common ground can be recognized and divergent and dichotomous goals can be realized or converted to more utilitarian goals. In individual relationships, conflicts can often be resolved

through cooperation and dialogue. This can also be true with collectives. Groups are generally connected by common goals and are usually willing to set aside differences to work toward goals. Focusing on commonalities by sharing, communicating, and cooperating is more related to caring than focusing on conflicts. Frequent collective consultations and values clarifications of the different groups involved would enhance relationships and cooperation between the health care factions. In addition, different health care factions are healthy to prevent one powerful faction (e.g., AMA) from gaining control over the system. Ultimately, the common goal of patient care will be facilitated by encouraging factions and productive sharing relationships between factions.

This sharing concept is paramount. Caring is sharing. Sharing values, sharing problems, and collectively reflecting or sharing ethical issues in group settings is a necessary part of encouraging sound relationships between collectives. This concept is consistent with Ferguson (1984) who calls for embracing the values of care and connection. This connection can help prevent conflicts between collectives and encourage collaborative and cooperative health care practices.

Caring about Collectives

Conflicts between perceived obligations can also occur. Although this dissertation has pointed out that the revisions of the Code have shown a shift in responsibility and accountability from the physician and employer to the patient and the public, the literature continues to focus on "conflicts of loyalties" (Glennon, 1985; Pieta, 1976; Poulin, 1984). This Collective Caring Model helps to resolve this confusion by pointing out that caring includes caring about the organization or institution that is the employer. The organization needs to continue to exist if it is to continue to be part of the health care system and deliver health care services, which is the common goal of the different health care factions. Towards that end the means of the organization need to be shared to facilitate understanding and support. It is suggested here that forums (i.e., conferences, meetings) be developed to facilitate Follett's (1924) cooperation and integration of different collectives, thus depersonalizing or repersonalizing the situation. Collective Caring means that the individuals and the collectives need to work together toward common goals (utilitarian outcomes). The whole situation needs to be studied and those concerned need to create the desired attitude for cooperative study and decision making (Metcalf,

1926).

Caring for staff, patients, other health care professionals and organizations are idealistic notions towards which nursing administration should strive. According to Follett (1924), an administrator needs to be an integrator and needs to study the whole situation and organize the scattered forces.

The point where individual caring interfaces with collectives is the point that seems to create difficulty for nurses socialized with individual, face-to-face, one-to-one values. Nurses have been socialized to value following rules. However, hospitals as complex health care organizations appear to have a utilitarian value system (Purtilo & Cassel, 1981). They are oriented toward providing the greatest good for the greatest number. The traditional value set for the professional nurse espousing individual patient care and patient advocacy does not address collectives. Nurse administrators deal with collectives. The nurse administrator is concerned with collectives of patients and functions as an advocate for collectives or the public.

Patient/Public Advocacy

The ethical principle upon which the patient advocate

model rests is the Kantian principle of respect for persons which is rule oriented (Muyskens, 1981; the Code, 1985). The right to self-determination (choice, autonomy) takes priority over promoting the patient's best interest (paternalism). A deontologist might hold that respect for autonomy is a duty. However, a utilitarian might believe that happiness is best obtained by the full use of one's autonomous choice. In conclusion, respect for autonomy is not the orientation of only one view of ethics. When applying this to nursing administration and collective caring, the nurse administrator needs to consider the public's interest and the public's right to choose. Happiness would be obtained by seeing the public interest or public values used for ethical decision making. In addition, public rights need to be protected from encroachment by those health care professionals who are promoting individual values or self-interests. The nursing administrator needs to function as a public advocate. Although the nursing administrator also has rights, those rights need to be constrained so that the public interest is promoted. For example, the living will legislation and associated trends clearly indicate the public supports patient autonomy or the right to self-determination. However, individual nurses, with personal values, have

considerable administrative discretion. According to Purtilo and Cassel (1981), professionals are obligated to constrain their own rights and do what is best for the patient, or in this case, the public. The nursing administrator espousing Collective Caring would promote institutional policies promoting the public interest, above her own interests. The nurse administrator could still share her personal ideas and ideals while working with groups and committees designed to plan for the future.

As public administrators, nurse administrators need to be aware of the current values of society or the public's interest in regard to health care and the nursing profession. Sources used by this author to help extract such values have included: the U.S. Constitution; a historical development of the Code; an analysis of the revisions of the Code; a historical perspective of nursing and nursing administration throughout the twentieth century; an analysis of articles with ethical themes published in nursing and nursing administration journals; as well as case law and statute law. Although this dissertation has focused on the collective values of the nursing profession and nursing administration, society's values about the profession as well as about health care and disease have also been evident in some of the sources (e.g., trends in

case and statute law; trends in health care settings). The public's interest or society's values are normative for nurse administrators employed in public organizations, because they have taken an oath to uphold the Constitution and the values of the regime or polity created by that instrument (Rohr, 1978). They are morally responsible and accountable as public administrators to the public which they serve.

The sources used by this author to illuminate the values of the nursing profession have shown some values that have endured the test of time. The ethical guidelines regarding protecting patients and the public against unethical or illegal practices and promoting efforts to meet the health needs of the public have been in each revision of the Code. Nursing administrators need to be well aware of such values. Such values need to be considered and addressed in regard to a quest for an ethical framework for nurse administrators. Both of these values refer more to collective behavior and action than to individual action and behavior. If a collective perspective was applied, individual scape-goating and unfair dismissal practices against individuals might be prevented. Especially if Follett's (1924) idea of depersonalizing or repersonalizing the situation was used by all to study the situation. Nurse administrators need to

support each other, the staff, and the health care organization in order to function as public advocates. In sum, to justify functioning as public advocates, nurse administrators need to be well aware of the profession's values as well as society's values. Only then will nurse administrators and collectives of staff feel secure enough to meet their ethical mandates as caring public advocates.

The nursing administrator who can function effectively and efficiently as a public advocate has the potential to influence health care policy and a more equitable distribution of health care resources. Ferguson (1984) and Moccia (1988) combine caring and social activism. Both authors encourage engagement in public discourse and policy decision-making. Again, nurse administrators socialized in the traditional ethic may have difficulty with collective decision-making about collectives. Health care policy is an approach to solving problems at the collective level which frequently involves decisions that balance the common good and individual rights.

For example, a current ethical concern of nurse administrators is the allocation of scarce resources. Limited resources used in one health care setting are not available for use in another setting. Cost for providing one resource (i.e., medical treatment) could be used for

research to prevent disease or promote health. There are no easy answers regarding the allocation of scarce resources. These types of concerns are related to questions of distributive justice and require a more utilitarian and situational approach (i.e., the Collective Caring Model) to problem solving. Nurse administrators need to be able to reflect with collectives on these types of questions about collectives in order to be able to consider advantages and disadvantages of the various options. Nursing administrators need to be involved in policy-making in order to provide the unique perspective of nursing and caring for and about collectives.

Nurse administrators need to be involved at the organizational level with decision-making committees. By asking questions and contributing to discussions, nursing can influence the political process and policy making. Policies which seem inappropriate need to be challenged. Otherwise, goals and missions cannot be achieved.

Nurse administrators are also in a position to encourage more consumer activism on boards and with community groups. Involvement begins locally with participation in community, schools and professional organizations. The nurse administrator can enhance consciousness in consumer groups about health care issues such as public rights and health

care access. Specifically, the target of the change toward collective caring is the public. The means for focusing on the public's interest and public health are the alternatives or options to be considered in policy decisions. Public policy making is a unique function of nursing administrators employed as public administrators.

Recommendations

An ethic (i.e., Collective Caring) for nursing administrators needs to be practical for a predominantly feminine profession and applicable for use with and for collectives and policy development. It needs to consider and support the public interest. In addition, such an ethic needs to enhance the commitment or responsibility of nursing administrators to protect the public as public advocates. The potential for Collective Caring to be accepted as a viable ethic for nursing administrators depends on the ability to understand and accept the concepts.

Education

The unique domain of nursing administration and its historical evolution needs to be taught in basic nursing courses. Staff nurses need to be aware of the differences in the value systems and domains of the two roles (i.e.,

nursing and nursing administration). More educational emphasis needs to be placed on ethics and values. The distinctive nature of public organizations and public administration needs to be taught. The policy-making process at all levels, beginning with the organizational level also needs to be included in educational curriculum. Nursing administrators could support a new journal for ethical problems facing nurse administrators. Administrators and educators could be encouraged to contribute. This would function as a long term record of ethical concerns for nursing administrators.

Action

Today, most health care organizations have networks of computers. Nurse administrators could set up a computer file for administrative ethics. Such a file could focus on past problems, the situation then, solutions, results and reading references.

Health care organizations could develop a department (e.g., Health Care Ethics Department) similar to the continuing quality improvement departments. Such a department would create a forum for different departments to share current ethical concerns. That department also could do integrated multidisciplinary research projects. Such

endeavors would unite and integrate nursing, administration and physicians. Educational ethics conferences for a multidisciplinary audience also would unite the various factions and encourage dialogue.

Conclusion

Nurse administrators, especially those employed as public administrators, need to use the concepts of Collective Caring and accept them as central to the role in order to function effectively and efficiently. Only then will the individuals feel confident enough to become involved as public advocates in policy making bodies at all levels. Collective Caring has the potential to help define relationships and enhance relationships within the health care system. The public's interest will also be enhanced.

The traditional ethic for nursing is inappropriate for nursing administration. It is recommended that the ideal of Collective Caring be critically examined and used as an ethical ideal for nursing administrators. Perhaps the integrity of the profession of nursing administration can be saved and justified by the application of Collective Caring. Collective Caring can be useful as a guide for the ideals of nursing administrators.

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APPENDIX A

A Suggested Code (1926)

The Relation of the Nurse to the Patient

The nurse should bring to the care of the patient all of the knowledge, skill and devotion which she may possess. To do this, she must appreciate the relationship of the patient to his family and to his community. Therefore the nurse must broaden her thoughtful consideration of the patient so that it will include his whole family and his friends, for only in surroundings harmonious and peaceful for the patient can the nurse give her utmost of skill, devotion and knowledge, which shall include the safe-guarding of the health of those about the patient and the protection of property.

The Relation of the Nurse to the Medical Profession

The term "medicine" should be understood to refer to scientific medicine and the desirable relationship between the two should be one of mutual respect. The nurse should be fully informed on the provisions of the medical practice act of her own state in order that she may not unconsciously support quackery and actual

infringements of the law. The key to the situation lies in the mutuality of aim of medicine and nursing; the aims, to cure and prevent disease and promote positive health, are identical, the technics of the two are different and neither profession can secure complete results without the other. The nurse should respect the physician as the person legally and professionally responsible for the medical and surgical treatment of the sick. She should endeavor to give such intelligent and skilled nursing service that she will be looked upon as a co-worker of the doctor in the whole field of health.

Under no circumstances, except in emergency, is the nurse justified in instituting treatment.

The Relation of the Nurse to the Allied Professions

The health of the public has come to demand many services other than nursing. Without the closest inter-relation of workers and appreciation of the ethical standards of all groups and a clear understanding of the limitations of her own group, the best results in building positive health in the community cannot be obtained.

Relation of Nurse to Nurse

The "Golden Rule" embodies all that could be written in many pages on the relation of nurse to nurse. This should be one of fine loyalty, of appreciation for work conscientiously done, and of respect for positions of authority. On the other hand, loyalty to the motive which inspires nursing should make the nurse fearless to bring to light any serious violation of the ideals herein expressed; the larger loyalty is that to the community, for loyalty to an ideal is higher than any personal loyalty.

Relation of the Nurse to Her Profession

The nurse has a definite responsibility to her profession as a whole. The contribution of individual service is not enough. She should, in addition, give a reasonable portion of her time to the furtherance of such advancements of the profession as are only possible through action of the group as a whole. This involves attendance at meetings and the acquisition of information at least sufficient for intelligent participation in such matters as organization and legislation.

The supreme responsibility of the nurse in relation to

her profession is to keep alight that spiritual flame which has illumined the work of the great nurses of all time.

APPENDIX B

A Tentative Code (1940)

A. General Responsibilities to the Profession

It is the responsibility of the nurse to:

a) Conduct herself as a woman of high ideals, to use every means to maintain the dignity and standards of her profession, and to extend its sphere of usefulness. Integrity, tolerance, and sympathetic understanding are characteristics which influence the personal conduct and social responsibility of the nurse. They are not the concern of the nurse alone, but have a definite influence on the standing of the nursing profession;

b) Improve the quality of nursing service through study, practice, and research;

c) Participate actively in the work of nursing organizations and allied groups, and in securing and maintaining nursing legislation for the protection of both the patient and the nurse. She should know the provisions of the nurse practice act in the state in which she is practicing, and she should cooperate in making it effective.

B. Relation to Patient

Section 1. The nurse should carry out professional

commitments and activities with meticulous care, with a generous measure of performance, and with fidelity toward those whom she serves. Honesty, understanding, gentleness, and patience should characterize all of the acts of the nurse. A sense of the fitness of things is particularly important.

Section 2. The confidences concerning individual or domestic life, which are intrusted to the nurse by a patient, and the defects of disposition or character which are observed, should be held as a trust, and should not be revealed except when imperatively required by law, or when deemed necessary to promote the patient's welfare. In the latter case, it may be necessary to confer with the physician or those having responsibility for the patient. In such a situation a wise course of action can be taken only through the exercise of discriminating judgment.

Section 3. In some instances, the economic status of a patient undoubtedly will command the gratuitous services of nurses; but the officers of endowed institutions and hospitals, whether governmental, voluntary, sectarian, or private, as well as organizations established for mutual benefit, or for accident, sickness, and life insurance plans, have no claim upon the nurse for unremunerated services. In an emergency she will of course do her full

share to see that patients are cared for. If an institution organized to provide adequate service for the sick, including nursing care, for any reason cannot fulfil this obligation, it should not expect to commandeer the unremunerated, or markedly underpaid, services of nurses. In the presence of genuine need of nursing service, which cannot be provided through the usual channels, nurses should do their part, but it should be recognized that the provision of nursing service under such conditions is the voluntary gift of nurses as individuals. Should problems arise similar to those mentioned above, they are to be referred to the nearest professional nursing agency such as a registry, or to a district or state nurses' association.

Section 4. The fee for nursing service rendered to individual patients or groups should not exceed that approved by local professional agencies which distribute nursing service.

C. Relation to Medical Profession

The term "medical profession" refers to those who practice scientific medicine, and the desirable relationship between members of the medical and nursing professions is one of mutual understanding and respect. The nurse should

be fully informed on the provisions of the medical practice act and other acts legalizing and governing the practice of various types of practitioners in her own state in order that she may support and comply with the provisions of these laws. The key to the situation lies in the identity of the aims of medicine and nursing. These aims--to cure and prevent disease and promote positive health--are recognized as basic by the members of both professions. The nurse respects the physician as the person legally and professionally responsible for the medical and surgical treatment of the sick. She will endeavor to give such intelligent and skilled nursing service that she will be regarded as co-worker of the physician in the whole field of health.

Except in an emergency, the nurse is not justified in instituting treatment. In case it is necessary for her to give first-aid treatment in the absence of a physician, such treatment should be reported as soon as possible to the attending physician.

Loyalty to the physician demands that the nurse conscientiously follow his instructions and that she build up the confidence of the patient in him. At the same time she will exercise reason and intelligence in carrying out orders. She is to avoid criticism of him to anyone but

himself, and, if necessary, to the proper administrative officers in the institution or agency where both may be working, or to the local medical professional society.

Because a nurse is conscientious in carrying out a physician's directions for the proper care of his patient and conforms to the rules and policies of the institution or agency in which she is serving, it need not follow that she necessarily conforms to the physician's ideas of social or other policy. Nor does it mean that she approves of all the policies and practices of the institution or agency in which she is serving, or of the professional organization of which the physician may be a member.

D. Relation to Nurse

The "Golden Rule" embodies all that could be written in many pages on the relation of nurse to nurse. This should be one of fine loyalty and helpfulness, and also, of appreciation for work conscientiously done. On the other hand, loyalty to the motive which inspires nursing should make the nurse fearless in bringing to light any serious violation of it.

E. Relation to Employer

The nurse is to regard contracts--written or oral--as ethical obligations to be fulfilled in letter and in spirit. However, changed conditions may justify her in seeking modification of such agreements. When the nurse is employed in an institution, agency, or organization, she is to give reasonable notification before leaving so that someone can be secured to fill the vacancy. The nurse, remembering that the welfare of patients demands continuity of service, will not leave a patient until she is assured that adequate relief can be provided.

F. Relation to Public

Section 1. Because the nurse is a good citizen and because her professional preparation especially qualifies her, she will welcome and utilize opportunities to offer suggestions and help for the health protection of the individual, the family, and the community. She will participate, according to her ability, in those local and national activities that are carried on for social improvement.

Section 2. It is her privilege and responsibility to do her part in securing and enforcing laws, sustaining

institutions, and promoting new measures which will advance the interests of humanity, and especially in cooperating with the proper authorities in the administration of laws and regulations for the protection of the public health. It is important, also, to assist in preventing the enactment of undesirable health legislation.

Section 3. The nurse will use every opportunity to enlighten the public concerning measures for the prevention and control of communicable diseases. When an epidemic prevails, she will continue her labors, with due precautions, even at risk to herself.

Section 4. A truly professional nurse with broad social vision will have a sympathetic understanding of different creeds, nationalities, and races and in any case she will not permit her personal attitude toward these various groups to interfere with her function as a nurse.

G. Relation of Nurse to Others

Section 1. The nurse has a basic concern for people as human beings, confidence in the fundamental power of personality for good, respect for religious beliefs of others, and a philosophy which will sustain and inspire others as well as herself. Failure to possess these qualities means inability to live up to her responsibilities

and to make the most of her opportunities.

Section 2. The nurse has definite ethical responsibilities to:

- a) The patient's family and friends. To them she can be a source of strength and comfort and a friendly, objective counsellor;
- b) Administrative officers and other personnel in the institution or agency in which she is employed. To these persons or groups she owes loyalty and the fullest cooperation, including the strictest economy in the use of all supplies;
- c) All individuals working for the welfare of patients, e.g., social workers, dietitians, librarians, physical-therapy technicians, and other technicians. Understanding of the function of these groups and cooperation with them increases harmony in the environment of the patient and promotes his health and welfare.

H. Responsibilities to Herself

A nurse is to keep herself physically, mentally, and morally fit, and to provide for her spiritual, intellectual, and professional growth. She should institute savings plans

which will bring her financial security in old age.

APPENDIX C

A Code for Professional Nurses (1950)

Professional nurses minister to the sick, assume responsibility for creating a physical, social, and spiritual environment which will be conducive to recovery, and stress the prevention of illness and promotion of health by teaching and example. They render health service to the individual, the family, and the community and co-ordinate their services with members of other health professions involved in specific situations.

Service to mankind is the primary function of nurses and the reason for the existence of the nursing profession. Need for nursing service is universal. Professional nursing service is therefore unrestricted by consideration of nationality, race, creed, or color.

Inherent in the code is the fundamental concept that the nurse subscribes to the democratic values to which our country is committed.

With reference to the following statements, the profession recognizes that a professional code cannot cover in detail all the activities and relationships of nurses, some of which are conditioned by personal philosophies and beliefs.

1. The fundamental responsibility of the nurse

is to conserve life and to promote health.

2. The professional nurse must not only be adequately prepared to practice, but can maintain professional status only by continued reading, study, observation, and investigation.

3. When a patient requires continuous nursing service, the nurse must remain with the patient until assured that adequate relief is available.

4. The religious beliefs of a patient must be respected.

5. Professional nurses hold in confidence all personal information entrusted to them.

6. A nurse recommends or gives medical treatment without medical orders only in emergencies and reports such action to a physician at the earliest possible moment.

7. The nurse is obligated to carry out the physician's orders intelligently, to avoid misunderstanding or inaccuracies by verifying orders and to refuse to participate in unethical procedures.

8. The nurse sustains confidence in the physician and other members of the health team; incompetency or unethical conduct of associates in the health professions should be exposed, but only to the proper authority.

9. The nurse has an obligation to give conscientious

service and in return is entitled to just remuneration.

10. A nurse accepts only such compensation as the contract, actual or implied, provides. A professional worker does not accept tips or bribes.

11. Professional nurses do not permit their names to be used in connection with testimonials in the advertisement of products.

12. The Golden Rule should guide the nurse in relationships with members of other professions and with nursing associates.

13. The nurse in private life adheres to standards of personal ethics which reflect credit upon the profession.

14. In personal conduct nurses should not knowingly disregard the accepted patterns of behavior of the community in which they live and work.

15. The nurse as a citizen understands and upholds the laws and as a professional worker is especially concerned with those laws which affect the practice of medicine and nursing.

16. A nurse should participate and share responsibility with other citizens and health professions in promoting efforts to meet the health need of the public--local, state, national, and international.

17. A nurse recognizes and performs the duties of

citizenship, such as voting and holding office when eligible; these duties include an appreciation of the social, economic, and political factors which develop a desirable pattern of living together in a community.

APPENDIX D

The Code for Professional Nurses (1960)

Professional status in nursing is maintained and enriched by the willingness of the individual practitioner to accept and fulfill obligations to society, co-workers, and the profession of nursing. The following statements constitute a guide for each individual nurse in fulfilling these obligations.

1. The fundamental responsibility of the nurse is to conserve life, to alleviate suffering, and to promote health.

2. The nurse provides services based on human need, with respect for human dignity, unrestricted by considerations of nationality, race, creed, color or status.

3. The nurse does not use professional knowledge and skill in any enterprise detrimental to the public good.

4. The nurse respects and holds in confidence all information of a confidential nature obtained in the course of nursing work unless required by law to divulge it.

5. The nurse as a citizen understands and upholds the laws and performs the duties of citizenship; as a professional person the nurse has particular responsibility to work with other citizens and health professions in

promoting efforts to meet health needs of the public.

6. The nurse has responsibility for membership and participation in the nurses' professional organization.

7. The nurse participates responsibly in defining and upholding standards of professional practice and education.

8. The nurse maintains professional competence and demonstrates concern for the competence of other members of the nursing profession.

9. The nurse assumes responsibility for individual professional actions and judgment, both in dependent and independent nursing functions, and knows and upholds the laws which affect the practice of nursing.

10. The nurse, acting through the professional organization, participates responsibly in establishing terms and conditions of employment.

11. The nurse has the responsibility to participate in study of and action on matters of legislation affecting nurses and nursing service to the public.

12. The nurse adheres to standards of personal ethics which reflect credit upon the profession.

13. The nurse may contribute to research in relation to a commercial product or service, but does not lend professional status to advertising, promotion, or sales.

14. Nurses, or groups of nurses, who advertise

professional services, do so in conformity with the dignity of the nursing profession.

15. The nurse has an obligation to protect the public by not delegating to a person less qualified any service which requires the professional competence of a nurse.

16. The nurse works harmoniously with, and sustains confidence in nursing associations, the physician, and other members of the health team.

17. The nurse refuses to participate in unethical procedures and assumes the responsibility to expose incompetence or unethical conduct in others to the appropriate authority.

APPENDIX E

A Code for Professional Nurses (1968)

Introduction

The development of a code of ethics is an essential characteristic of a profession, and provides one means whereby professional standards may be established, maintained, and improved. A code indicates a profession's acceptance of the responsibility and trust with which it has been invested. Each practitioner, upon entering a profession, inherits a measure of that responsibility and trust and the corresponding obligation to adhere to standards of ethical practice and conduct set by the profession.

The Code for Nurses, adopted by the American Nurses' Association in 1950 and revised in 1960 and 1968, is intended to serve the individual practitioner as a guide to the ethical principles that should govern her nursing practice, conduct, and relationships. The Code and the accompanying interpretive statements clarify the essential areas in which definite standards of practice and conduct are seen as essential to the full and ethical discharge of the nurse's responsibility to the public, to other groups with whom she may be associated, and to the profession of

which she is a member. Each nurse has an obligation to uphold and adhere to the Code in her individual practice and to ensure that her colleagues do likewise.

Guidance and assistance in implementing the Code in local situations may be obtained from committees or councils on nursing practice of State Nursing Associations. Further information about the Code and its interpretation may be obtained from the ANA Nursing Practice Department.

THE CODE FOR NURSES

1. The nurse provides services with respect for the dignity of man, unrestricted by considerations of nationality, race, creed, color, or status.

2. The nurse safeguards the individual's right to privacy by judiciously protecting information of a confidential nature, sharing only that information relevant to his care.

3. The nurse maintains individual competence in nursing practice, recognizing and accepting responsibility for individual actions and judgments.

4. The nurse acts to safeguard the patient when his care and safety are affected by incompetent, unethical, or illegal conduct of any person.

5. The nurse uses individual competence as a criterion in accepting delegated responsibilities and assigning nursing activities to others.

6. The nurse participates in research activities when assured that the rights of individual subjects are protected.

7. The nurse participates in the efforts of the profession to define and upgrade standards of nursing practice and education.

8. The nurse, acting through the professional organization, participates in establishing and maintaining conditions of employment conducive to high-quality nursing care.

9. The nurse works with members of health professions and other citizens in promoting efforts to meet health needs of the public.

10. The nurse refuses to give or imply endorsement to advertising, promotion, or sales for commercial products, services, or enterprises.

APPENDIX F

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A Code for Professional Nurses (1976)

Introduction

The development of a code of ethics is an essential characteristic of a profession and provides one means for the exercise of professional self-regulation. A code indicates a profession's acceptance of the responsibility and trust with which it has been invested by society. Upon entering the profession of nursing, each person inherits a measure of the responsibility and trust that has accrued to nursing over the years and the corresponding obligation to adhere to the profession's code of conduct and relationships for ethical practice.

The Code for Nurses, adopted by the American Nurses' Association in 1950 and periodically revised, serves to inform both the nurse and society of the profession's expectations and requirements in ethical matters. The Code and the Interpretive Statements together provide a framework for the nurse to make ethical decisions and discharge responsibilities to the public, to other members of the health team, and to the profession. While it is impossible to anticipate in a code every type of situation that may be encountered in professional practice, the direction and

suggestions provided here are widely applicable.

The Code for Nurses and Interpretive Statements are both directed toward present-day practice. Previous Codes have been more prescriptive, identifying codes of both personal and professional behavior, describing appropriate relationships with physicians and other health professionals, and identifying certain responsibilities of the nurse as a citizen, an employee, and a person. The present Code, while remaining prescriptive, depends more on the nurse's accountability to the client, and in that sense, represents a change to an ethical code.

The requirements of the Code may often exceed, but are never less than those of the law. While violations of the law may subject the nurse to civil or criminal liability, the constituent associations may reprimand, censure, suspend, or expel ANA members from the Association for violations of the Code. The possible loss of the respect and confidence of society and one's colleagues are serious sanctions which may result from violation of the Code. Each nurse has a personal obligation to uphold and adhere to the Code and to insure that nursing colleagues do likewise.

Guidance and assistance in implementing the Code in local situations may be obtained from the American Nurses Association or its state constituents.

PREAMBLE

The Code for Nurses is based on belief about the nature of individuals, nursing, health, and society. Recipients and providers of nursing services are viewed as individuals and groups who possess basic rights and responsibilities, and whose values and circumstances command respect at all times. Nursing encompasses the promotion and restoration of health, the prevention of illness, and the alleviation of suffering. The statements of the Code and their interpretation provide guidance for conduct and relationships in carrying out nursing responsibilities consistent with the ethical obligations of the profession and quality in nursing care.

CODE FOR NURSES

1. The nurse provides services with respect for human dignity and the uniqueness of the client unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems.

2. The nurse safeguards the client's right to privacy by judiciously protecting information of a confidential nature.

3. 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.

4. The nurse assumes responsibility and accountability for individual nursing judgments and actions.

5. The nurse maintains competence in nursing.

6. The nurse exercises informed judgment and uses individual competence and qualifications as criteria in seeking consultation, accepting responsibilities, and delegating nursing activities to others.

7. The nurse participates in activities that contribute to the ongoing development of the profession's body of knowledge.

8. The nurse participates in the profession's efforts to implement and improve standards of nursing.

9. The nurse participates in the profession's efforts to establish and maintain conditions of employment conducive to high quality nursing care.

10. The nurse participates in the profession's effort to protect the public from misinformation and misrepresentation and to maintain the integrity of nursing.

11. The nurse collaborates with members of the health professions and other citizens in promoting community and national efforts to meet the health needs of the public.

APPENDIX G

A Code for Professional Nurses (1985)

PREAMBLE

A code of ethics makes explicit the primary goals and values of the profession. When individuals become nurses, they make a moral commitment to uphold the values and special moral obligations expressed in their code. The Code for Nurses is based on a belief about the nature of individuals, nursing, health, and society. Nursing encompasses the protection, promotion, and restoration of health; the prevention of illness; and the alleviation of suffering in the care of clients, including individuals, families, groups, and communities. In the context of these functions, nursing is defined as the diagnosis and treatment of human responses to actual or potential health problems.

Since clients themselves are the primary decision makers in matters concerning their own health, treatment, and well-being, the goal of nursing actions is to support and enhance the client's responsibility and self-determination to the greatest extent possible. In this context, health is not necessarily an end in itself, but rather a means to a life that is meaningful from the client's perspective.

When making clinical judgments, nurses base their

decisions on consideration of consequences and of universal moral principles, both of which prescribe and justify nursing actions. The most fundamental of these principles is respect for persons. Other principles stemming from this basic principle are autonomy (self-determination), beneficence (doing good), nonmaleficence (avoiding harm), veracity (truth-telling), confidentiality (respecting privileged information), fidelity (keeping promises), and justice (treating people fairly).

In brief, then, the statements of the code and their interpretation provide guidance for conduct and relationships in carrying out nursing responsibilities consistent with the ethical obligations of the profession and with high quality in nursing care.

Introduction

A Code of ethics indicates a profession's acceptance of the responsibility and trust with which it has been invested by society. Under the terms of the implicit contract between society and the nursing profession, society grants the profession considerable autonomy and authority to function in the conduct of its affairs. The development of a code of ethics is an essential activity of a profession

and provides one means for the exercise of professional self-regulation.

Upon entering the profession, each nurse inherits a measure of both the responsibility and the trust that have accrued to nursing over the years, as well as the corresponding obligation to adhere to the profession's code of conduct and relationships for ethical practice. The Code for Nurses with Interpretive Statements is thus more a collective expression of nursing conscience and philosophy than a set of external rules imposed upon an individual practitioner of nursing. Personal and professional integrity can be assured only if an individual is committed to the profession's code of conduct.

A code of ethical conduct offers general principles to guide and evaluate nursing actions. It does not assure the virtues required for professional practice within the character of each nurse. In particular situations, the justification of behavior as ethical must satisfy not only the individual nurse acting as a moral agent but also the standards for professional peer review.

The Code for Nurses was adopted by the American Nurses' Association in 1950 and has been revised periodically. It serves to inform both the nurse and society of the profession's expectations and requirements in ethical

matters. The code and the interpretive statements together provide a framework within which nurses can make ethical decisions and discharge their responsibilities to the public, to other members of the health team, and to the profession.

Although a particular situation by its nature may determine the use of specific moral principles, the basic philosophical values, directives, and suggestions provided here are widely applicable to situations encountered in clinical practice. The Code for Nurses is not open to negotiation in employment settings, nor is it permissible for individuals or groups of nurses to adapt or change the language of this code.

The requirements of the code may often exceed those of the law. Violations of the law may subject the nurse to civil or criminal liability. The state nurses' associations, in fulfilling the profession's duty to society, may discipline their members for violations of the code. Loss of the respect and confidence of society and of one's colleagues is a serious sanction resulting from violation of the code. In addition, every nurse has a personal obligation to uphold and adhere to the code and to ensure that nursing colleagues do likewise.

Guidance and assistance in applying the code to local

situations may be obtained from the American Nurses' Association and the constituent state nurses' associations.

CODE FOR NURSES

1. The nurse provides services with respect for human dignity and the uniqueness of the client, unrestricted by consideration of social or economic status, personal attributes, or the nature of health problems.

2. The nurse safeguards the client's right to privacy by judiciously protecting information of a confidential nature.

3. The nurse acts to safeguard the client and the public when health care and safety are affected by the incompetent, unethical, or illegal practice of any person.

4. The nurse assumes responsibility and accountability for individual nursing judgments and acts.

5. The nurse maintains competence in nursing.

6. The nurse exercises informed judgment and uses individual competence and qualifications as criteria in seeking consultation, accepting responsibilities, and delegating nursing activities to others.

7. The nurse participates in activities that contribute to the ongoing development of the profession's body of

knowledge.

8. The nurse participates in the profession's efforts to implement and improve standards of nursing.

9. The nurse participates in the profession's efforts to establish and maintain conditions of employment conducive to high quality nursing care.

10. The nurse participates in the profession's effort to protect the public from misinformation and misrepresentation and to maintain the integrity of nursing.

11. The nurse collaborates with members of the health professions and other citizens in promoting community and national efforts to meet the health needs of the public.

APPENDIX H

Commonwealth of Pennsylvania



CONSTITUTIONAL OATH OF OFFICE

COMMONWEALTH OF PENNSYLVANIA

County of _____

} SS:

I do solemnly swear (or affirm) that I will support, obey and defend the Constitution of the United States and the Constitution of this Commonwealth and that I will discharge the duties of my office with fidelity.

Taken, sworn and subscribed before me

this _____ day of

_____ A.D. 19 _____

(SEAL) _____

SIGNATURE

NAME (Print or Type)

OFFICE TITLE

NOTE: The foregoing oath shall be administered by some person authorized to Administer oaths.

The oaths of STATE OFFICERS, JUSTICES OF THE SUPREME COURT and JUDGES OF THE SUPERIOR AND COMMONWEALTH COURTS shall be filed in the office of the Secretary of the Commonwealth.

The oaths of other judicial and county officers shall be filed with the Prothonotary of the county in which oath is taken.

OATH OR AFFIRMATION OF ALLEGIANCE

I, _____, do solemnly swear [or affirm] that I will be true and faithful to the State of Vermont, and that I will not, directly or indirectly, do any act or thing injurious to the Constitution or Government thereof. [If an oath] So help me God. [If an affirmation] Under the pains and penalties of perjury.

I do solemnly swear [or affirm] that I will support the Constitution of the United States. [If an oath] So help me God. [If an affirmation] Under the pains and penalties of perjury.

OATH OR AFFIRMATION OF OFFICE

I, _____, do solemnly swear [or affirm] that I will faithfully execute the office of _____ for _____ and will therein do equal right and justice to all men, to the best of my judgment and ability, according to law. [If an oath] So help me God. [If an affirmation] Under the pains and penalties of perjury.

Sign your name as in commission here _____

Give your town or city of residence _____

CERTIFICATE OF AUTHORITY BEFORE WHOM OATH IS TAKEN

STATE OF VERMONT

_____ County, ss.

I hereby certify that on the _____ day of _____, 198____ personally appeared before me _____ at _____ in said county of _____ and took and subscribed the foregoing oaths or affirmations of office and allegiance.

Signature of authority administering oath _____

Official character _____

State of New York



COUNTY _____ } ss.:

I do solemnly swear (or affirm) that I will support the constitution of the United States, the constitution of the State of New York, and that I will faithfully discharge the duties of the office of

_____ (Title of position)

_____ (Department)

according to the best of my ability.

Subscribed and sworn to before me this

_____ day of _____, 19 _____ }

_____ (Signature of appointee)

_____ (Type name of appointee)

_____ (Type address of appointee)

_____ (Notary, Commissioner of Deeds, or other qualified officer)

I hereby acknowledge receipt of a copy of Public Officer's Law, sections 73 through 78, have read the same, and agree to conform to the provisions thereof.

_____ (Signature of appointee)

_____ Date

STATE OF NEW JERSEY :
 :SS.
County of _____ :

I, _____, do solemnly swear
(or affirm) that I will support the Constitution of the United States
and the Constitution of the State of New Jersey; that I will bear true
faith and allegiance to the same and to the Governments established in
the United States and in this State, under the authority of the
people; and that I will faithfully impartially and justly perform all
the duties of the office of _____

_____ according to the best of my ability. (So help me God).*

Sworn and subscribed to
before me this _____ day of _____
_____ A.D. 19 _____.

*Person taking oath has the option of including "So help me God", if
he so desires.

DECISIONS UNDER PRIOR PROVISIONS

ANALYSIS

1. Conviction.
2. Felony.

1. Conviction.

Nothing in this section purported in any way to limit or restrict the plenary power of the legislature to prescribe any other qualifications or disqualifications or conditions for the holding of public office. The general assembly, therefore, was well within its inherent power, unrestricted by constitutional limitations, when it ratified and adopted the provisions set forth in a city charter that were interpreted to prohibit an incumbent mayor convicted of a felony from seeking to fill the unexpired portion of his term. *Geich v. State Bd. of Elections*, — R.I. —, 482 A.2d 1204 (1984).

No Rhode Island constitutional provision or statute disqualified a person from holding public office merely because that person was convicted of an offense that results in incarceration for a period of time. *Violet v. Voccola*. — R.I. —, 497 A.2d 709 (1985).

Conviction and imprisonment for a misdemeanor under federal law did not disqualify that person from holding public office in Rhode Island. *Violet v. Voccola*, — R.I. —, 497 A.2d 709 (1985).

2. Felony.

Although plaintiff was duly elected for the office of representative, since he had been previously convicted of an infamous crime (R.I. Const., amend. 24, § 1 was operative at that time), the oath of office was properly denied him. *Bailey v. Burns*. 118 R.I. 428, 375 A.2d 203 (1977).

Section 3. Oath of general officers. — All general officers shall take the following engagement before they act in their respective offices, to wit: You

being by the free vote of the electors of this state of Rhode Island and Providence Plantations, elected unto the place of _____ do solemnly swear (or, affirm) to be true and faithful unto this state, and to support the Constitution of this state and of the United States; that you will faithfully and impartially discharge all the duties of your aforesaid office to the best of your abilities, according to law: So help you God. [Or: This affirmation you make and give upon the peril of the penalty of perjury.]

Comparative Provisions. Oath of officers:

Conn. 1965 Const., art. Eleventh, § 1.
Mass. Const. [§ 92].

Section 4. Oath of general assembly members, judges, and other officers. — The members of the general assembly, the judges of all the courts, and all other officers, both civil and military, shall be bound by oath or affirmation to support this Constitution, and the Constitution of the United States.

Cross References. Engagement of office of judges, § 8-3-1.
Oath of office, § 36-1-2.
Oaths of town and city officers, § 45-4-11.

Comparative Provisions. Oaths of office:
Conn. 1965 Const., art. Eleventh, § 1.
Mass. Const. [§ 92].

Section 5. Administration of oaths. — The oath or affirmation shall be administered to the governor, lieutenant governor, senators, and representatives by the secretary of state, or, in the absence of the secretary of state by the attorney-general. The secretary of state, attorney-general, and general treasurer shall be engaged by the governor, or by a justice of the supreme court.

APPOINTMENT AFFIDAVITS

_____ (Name of appointee) _____ (Title of appointment)

_____ (Department or agency) _____ (Director or Division) _____ (Place of appointment)

I, _____, do solemnly swear (or affirm) that—

A. OATH OF OFFICE

I will support and defend the Constitution of the United States against all enemies, foreign and domestic; that I will bear true faith and allegiance to the same; that I take this obligation freely, without any mental reservation or purpose of evasion; and that I will well and faithfully discharge the duties of the office on which I am about to enter. So help me God.

B. AFFIDAVIT AS TO STRIKING AGAINST THE FEDERAL GOVERNMENT

I am not participating in any strike against the Government of the United States or any agency thereof, and I will not so participate while an employee of the Government of the United States or any agency thereof.

C. AFFIDAVIT AS TO PURCHASE AND SALE OF OFFICE

I have not nor has anyone acting in my behalf, given, transferred, promised or paid any consideration for or in expectation or hope of receiving assistance in securing this appointment.

_____ (Signature of appointee)

Subscribed and sworn (or affirmed) before me this _____ day of _____, 19____,

at _____ (City) _____ (State)

[SEAL]

_____ (Signature of officer)

Commission expires _____
(If of a Notary Public, the date of expiration of his/her Commission should be shown)

_____ (Title)

NOTE.—The oath of office must be administered by a person specified in 5 U.S.C. 2902. The words "So help me God" in the oath and the word "swear" wherever it appears above, should be stricken out when the appointee elects to affirm rather than swear to the affidavit; only these words may be stricken and only when the appointee elects to affirm the affidavit.

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