



## Learning from Nursing

by Judith Andre, PhD

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"[T]he situation of nurses, with its strong tensions between power and powerlessness, represents the situation of most of us."<sup>1</sup> So wrote Andrew Jameton some years ago. If he is right — and I think he is — then we can all learn from looking at nursing more closely.

It's surprisingly difficult to do this. Many different factors make it hard to really see the field. One is the structure of nurse-patient encounters: patients rarely choose the nurse who cares for them, and often do not even know her name. The distinctive uniforms and caps of the past no longer tell us who is a doctor, who a nurse, who a phlebotomist. Class and gender put up blinders, as does our Platonic tendency to value the theoretical over the practical.

A major help in understanding nursing is now available in journalist Suzanne Gordon's *Life Support: Three Nurses on the Front Line*. Let me share a small example from the working life of a nurse in an oncology clinic. As she schedules chemotherapy sessions and administers medication during them, her work fuses the mundane with the highly expert. She knows, for instance, that one of her patients had an earlier bout with an uglier cancer, for which chemotherapy was especially harsh, and so schedules this woman's current treatment in a setting completely unlike the earlier one; she even finds the patient a new route to take through the hospital to reach the unit. When the nurse administers chemotherapy, she double-checks the dosages prescribed, works with technical equipment, and watches intently for signs of adverse reactions, possibly life-threatening. When these occur, she recognizes and responds to them within seconds. Later, in a quieter moment, she talks with a man near death, listening mostly, as he tells her stories that give form and meaning to his memories and his life.

Gordon's book opens up a world invisible to most of us — even, oddly enough, to physicians. (Gordon describes the ways medical training fails in this regard.) The price of nursing's invisibility — or rather, of our inattention — is great. The recent, much-cited SUPPORT study, for instance, about treatment of the dying, ignored staff nurses, who typically know the patient and family in more depth than anyone on the service. A study which recognized both the unique position of staff nurses and the entrenched barriers to doctor-nurse communication would have been more useful.

Recent public outcry over shortened hospital stays is similarly distorted. Few people realize that one of a hospital's most essential provisions is nursing care. Hospitals do make it much easier for doctors to see patients, but theoretically this contact could take place at home or in the office. It is the nurses who are within call 24 hours a day, who not only carry out "doctors' orders," but help patients understand them, evaluate symptoms to see if a physician should be contacted again, and help with everything from getting out of bed to changing dressings to accepting a changed and possibly damaged body. Why is it that none of the headlines, protests, and legislative mandates have concerned the ratio of nurses to patients within hospitals? This ratio may predict more about patient well-being than even the quality of medical care does. But

the public does not know enough about changes in this ratio to care about it. Similarly, when doctors felt silenced by "gag clauses" in their contracts with MCOs, there was outrage. In comparison, the institutional difficulty a nurse has in speaking up (which I will describe in more detail below) is virtually unknown to the general public.

Paying more attention to nursing would improve the aim of health care research and of political action. It would also deepen ethical and bioethical theory in a number of ways: it provides an interesting set of moral concepts, including a taxonomy of moral distress and a different approach to moral development; it offers a history of collective action in the face of (relative) powerlessness; finally — perhaps ironically — nurses can tell us that marginality occasionally offers a moral advantage.

First, the concepts that are illuminating. The term "moral distress" is heard frequently today, as physicians deal with "managed care" and find themselves unable to provide patients with the treatment they once could. But the term originated years ago in the literature of nursing ethics, developed to contrast with the "dilemmas" that were then the staple of *medical* ethics. In a dilemma, one does not know the right thing to do. Moral distress, in contrast, arises when one "makes a judgment [which] the institution or [one's] co-workers make it difficult or impossible . . . to act [upon]."<sup>2</sup> What results are feelings of frustration, anger, and guilt, a sense of moral responsibility accompanied by the knowledge that one cannot change what is happening.<sup>3</sup> Distress of course *generates* dilemmas, especially about how much resistance, if any, one should mount. Moral distress comes in different kinds and degrees: the feelings of an intimate observer, watching, say, a resuscitation attempt on someone who had not wanted it; more agonizingly, the feelings of those who have to take part, or even do it by themselves. As Joan Liaschenko remarks, "Nurses are in the peculiar position of 'causing' much of the suffering of their patients. . . ." One nurse remarked, "I'm the enforcement tool of a large, university hospital."<sup>4</sup> The felt loss of integrity can be acute. In addition there is the sense of being silenced: Liaschenko's subjects learned gradually over time how to exert pressure, how to speak up. Not everyone does. Even in Liaschenko's study, "not a single [nurse] reported an instance where treatment was stopped on their testimony."

A final moment of moral distress occurs afterward: uneasy memories of the patient's suffering and one's own (coerced) part in it. This may be one reason some nurses learn to speak up even if they expect not to be heard; it makes the outcome easier to bear.

Understanding moral distress in some detail is useful for everyone. It can help us recognize suppressed aspects of our own experience, as citizens or family members or employees; what we can put into words we may be able to change. Even when change is unlikely, simply being able to name suffering makes it easier to bear. In addition the idea of moral distress might make us more sensitive to the possibility that we cause it in others: in our students, or our children, or the clerical staff, or anyone less powerful than ourselves.

Nursing literature also provides a distinctive way to think about moral development. The mainstream discussion has focused on three figures: Lawrence Kohlberg, who described six stages of maturity in moral judgment; Carol Gilligan, who articulated a different pathway, focused not on balancing rights but on establishing relationships; and James Rest, who pointed out that the moral growth includes more than improved thinking about how to resolve dilemmas. It also involves learning to recognize moral conflict, and developing the strength to carry out one's resolves. Patricia Benner, RN and PhD, looks at the whole question in a different way. Among other things she points out that acting morally is a skill: one must, for instance, learn *how* to be an effective help to others, not just *that* this is one's duty. She also notes that nurses capture what they have learned in stories about their failures and successes. As do we all! But this skills-and-stories approach to moral growth has been little explored outside nursing.

The stories some nurses tell involve unions, strikes, and other political action. This is another way in which we all can learn from nursing. Moral work, the practical side of ethics, demands more than reflection about choices and ideals. It requires devising ethical means: strategies that are at once effective, respectful, and honest, that minimize pain, and so on. Within institutions — or bureaucracies, if you will — moral work may well demand collective action. American physicians, accustomed to contracting as individuals with hospitals, insurers, and HMOs, are only now beginning to think in more aggregate terms. Those of us who teach medical students — and especially those of us who teach them ethics — might learn from one team of nurse researchers who argued that students can put their principles into practice only if they "master the practicalities of bureaucratic organizations."<sup>5</sup>

Some practical moral work is dramatic. An entire issue of *Nursing Ethics*, for instance, was devoted to the issue of whether nurses should strike. Contributors from around the world wrote about the history, legality, and especially the ethics of strike actions. Every writer held that strikes by nurses are, in rare circumstances, morally legitimate, even required: a strike may be the only way to bring about proper patient care. But the issue covered a range of alternative action as well: educating the public, enlisting the support of other health professionals, working through the media, putting on demonstrations, and mounting petition campaigns. (This strategy last took a particularly interesting form in Japan.) The writers also gave precautions, ways to ensure that no one who really needs care suffers from its lack. The editors' essential points are that although nurses are properly reluctant to strike (and some are opposed in conscience) strikes do happen and have been successful. Strong arguments can be made that they are occasionally justified.

In contrast to such public and dramatic steps, nursing also offers interesting, quieter, forms of moral action. Nurses acquire a whole toolbox of ways to speak up, for instance: "I'm not comfortable with. . . ." "The family is thinking/feeling/. . . ." "There might be a legal issue here. . . ." They also learn how to enlist allies: supervisors, chaplains, social workers, the ethics committee, the medical director. These are tools that medical students and graduate students, and residents and junior faculty, could adapt to their own purposes.

Protests are only one kind of moral work. A different sort involves helping a team work well together. Nursing supervisors can describe many different techniques here: sharing grief when it had accumulated unbearably in a neonatal unit (a session which the residents heard of with envy); a workshop on gossip; "contracts" in which team members agree that when they have problems working with someone they will talk *with* her rather than *about* her. The quietest forms of moral work consist simply in silence: not passive or sullen, but supportive. One writer describes 'ethical listening' as an independent nursing intervention, one which helps clients resolve ethical problems.<sup>6</sup> Melanie McLeod identifies the different ways in which silence enriches the nurse-patient relationship.

All of this leads to my last point. An attentive observer finds in nursing both conceptual resources and a rich tradition of moral action; she might also discover a paradox. At times there is a moral advantage in the mundane, in the marginal, and even powerlessness.

What are the advantages in doing mundane work? Nursing, in spite of its ever-growing technical demands, still provides some opportunities that have become rare in medicine: the chance to be with someone sick and suffering over an extended period of time, while nothing dramatic is happening. Let me hasten to say that nurses are hard pressed for time and overloaded with work, just as doctors are. But some of what nursing requires — feeding, washing, or dressing a patient, for instance — puts them in extended and fairly quiet contact with the patient or family. This allows a nurse to be present in a particularly attentive way. To give one example, one nurse recognized that a couple whose infant son had died were not ready, even an hour later,

to leave him. She invited them to share her tasks of washing and dressing the baby's body, and during that time to tell her about happier times in the baby's life. This was the beginning of their healing.<sup>7</sup>

Marginality has its own (occasional) advantages. Patricia Hill Collins coined the phrase "outsider within" to express the distinct perspective open to those who are part of a scene in some senses but not in all. "Outsiders within" sometimes see things others do not. To complicate the metaphor a bit, they are also sometimes "caught in the middle." But this can be a useful location: "the nurse who makes sure [to be] present for the detailed explanation of a proposed surgery" can help a frightened patient in way other doctors or family members would find it harder to accomplish.<sup>8</sup> They are too far inside, or too far outside, to be able to claim a place at this particular table.

Finally, even powerlessness occasionally has advantages. I was struck by this when teaching a unit on "bad outcomes" in health care. The various authors, from anthropology, medicine, law, and literature, focused on the doctor's suffering, on evaluating culpability, on systems of retribution and redress: deep and important questions. But suddenly we came upon Amy Haddad's poem "Dehiscence," in the voice of a nurse caring for someone whose surgical wound has torn open and cannot be repaired. In striking contrast to everyone else we had read, this woman's focus was on helping the patient, soothing, comforting, and cleaning him. By no means am I implying that our other authors were indifferent to the patients; the clinicians in particular had gone to heroic lengths to put things right. Nor am I denying that nurses carry serious responsibilities and, like everyone else, can make terrible mistakes. I am only pointing to a particular woman involved in a situation she had not created. I puzzled about the striking contrast offered by Haddad's poem to the other material we had read, and finally understood that the nurse described was emotionally free to focus on the patient, and especially on the patient's experience, in a way that is less possible when one must also be tracking one's own accountability.

There is much to learn from nursing: about political action and research strategies, about moral action and moral experience. But first we must learn to pay attention.

#### NOTES

1. Andrew Jameton, "Dilemmas of Moral Distress: Moral Responsibility and Nursing Practice," *AWONN's Clinical Issues in Perinatal and Women's Health Nursing*, 4, no. 4 (1993): 542-551.
2. Jameton, 542.
3. J.M. Wilkinson, "Moral Distress in Nursing Practice,: Experience and Effect," *Nursing Forum* 23, (1987-88): 16-29, cited in Jameton.
4. Joan Liaschenko, "Artificial Personhood: Nursing ethics in a Medical World," *Nursing Ethics* 2, no. 3 (1995): 188-9.
5. Hilary Ha-ping Yung, "The Relationship Between Role Conception and Ethical Behaviour of Student Nurses in Hong Kong," *Nursing Ethics* 4, no. 2 (1997).
6. Miriam E. Cameron and Marjorie A Schaffer, "Tell Me the Right Answer: A Model for Teaching Nursing Ethics," *Journal of Nursing Education* 31, no. 8 (Oct 1992): 379.
7. Bev D'Angio, "A Rare Moment in Time Leaves Special Bond for Nurse, Family," *AACN News* [date unknown]
8. Patricia Murphy, "Clinical Ethics: Must Nurses be Forever in the Middle?" *Bioethics Forum*, Midwest Bioethics Center, (Fall 1993).



## Bioethics and Cultural Diversity: Present and Future Initiatives

by Howard Brody, MD

*Center for Ethics and Humanities in the Life Sciences*

The Summer 1997 newsletter from the Center for Bioethics at the University of Pennsylvania contains a brief article by its director, Arthur Caplan, called, "Race and Bioethics." Caplan reflects upon the sea of white faces that one sees in the audience of almost all national conferences on bioethics, and talks about some possible initiatives to remedy the lack of persons of color in our discipline. He notes how hard this is to do at a time when the American public and society seem to be in "full-blown retreat from affirmative action." Caplan proceeds to list some reasons why race matters specifically for the fields of bioethics and humanities in health care.

For some years now, the Center for Ethics and Humanities has been very concerned about the lack of racial and ethnic diversity within the field of bioethics, and has begun a variety of pilot activities to see what we can do at Michigan State to redress this deficiency. I want now briefly to reflect on why we are doing this and where we stand in this process.

I agree with Caplan that one need not look outside our discipline in order to find justification for efforts to recruit more scholars from minority backgrounds. We are not in any important way, in my estimation, talking about social justice and the creation of new job opportunities for groups that have traditionally been discriminated against in the American work place. Instead, we are talking about a growing and expanding body of knowledge, and the eventual impoverishment of that discipline if we do not work to increase the number of voices representing minority perspectives in its internal dialogue. The debate over affirmative action generally has suffered from the focus on individual rights. We assume that the only reason to hire a person of color, or admit a student of color, is because of some sense that we owe this to that individual. That naturally sets up the question of why some other person, who did not get that job or position, was viewed as less worthy. This focus on the individual ignores the importance of communities and institutions. We tend not to ask the question of whether the whole institution would be substantially better off for having more people of color representing diverse cultural viewpoints represented among its members. The very idea that I, as a white male, benefit greatly when Michigan State University becomes a more diverse institution -- and, correspondingly, would be deprived of something very substantial were Michigan State University to become less diverse -- is a bit of wisdom often lost sight of in this discussion.

In general, Michigan State University provides a very supportive environment for enhancing cultural diversity and recruiting students and faculty from diverse backgrounds. Therefore, the Ethics and Humanities at MSU ought to be a national leader in promoting greater minority recruitment in bioethics and health care humanities. Initially, we sought extramural funding specifically earmarked for such a project, only to be turned down by a number of government agencies and foundations. Accordingly, we have had to scale back our efforts to see what could be done with existing University resources.

Among a number of current initiatives, we are planning future conferences on minority perspectives in bioethics. We have begun the process of meeting with various faculty and units around the campus to gain advice and assistance in planning such conferences. In the end, we would like to do a series of conferences, each one of which addresses a particular bioethical issue from a multi-cultural perspective. One of the first in the series might be "The Role of the Family in Making Health Care Decisions." At each of these conferences, we would bring together a diverse set of speakers representing different minority communities, each to address the central question.

We would hope that conferences like this would have an impact beyond the audience who attends. By publicizing these conferences, we believe that we could do more to signal to undergraduate students that Michigan State University is a friendly environment to pursue graduate study in bioethics or humanities. Perhaps by inviting speakers representing colleges reaching historically minority student populations, we would also signal to key faculty advisors of our interest in this field. Perhaps those faculty would then recommend that their most talented undergraduate students consider graduate study at MSU.

We plan this year to continue to meet with the relevant units and organizations at MSU who could best advise us on how to do this. I welcome input and advice from anyone reading this article with whom we have not already discussed this project.



## The Center's Adjunct Faculty

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Dedria Barker  
Information Specialists

Martin Benjamin  
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Vence Bonham  
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Daniel Bronstein  
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Doug Brown  
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Renee Canady  
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Joy Curtis  
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David Doukas  
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Alice Dreger  
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## Center News and Announcements

**Leonard Fleck** did a morning conference for the surgery residents at Sinai Hospital in Detroit in November on the topic “Genetic Responsibility: Emerging Ethical Issues.”

**Judith Andre** spoke on women’s issues in managed care at the Detroit Women’s Forum in November.

**Judith Andre** took part in a panel discussion on informed consent at Sparrow Hospital in November.

At the joint meeting of the American Association of Bioethics, the Society for Bioethics Consultation, and the Society for Health and Human Values, **Judith Andre** gave a response to *The Perversion of Autonomy* by Bruce Jennings and Willard Gaylin.

**Scot Yoder**’s paper, “Rethinking Professional Expertise” received the award for the best paper presented by a student at the joint meeting of the American Association of Bioethics, the Society for Bioethics Consultation, and the Society for Health and Human Values.

**Leonard Fleck** conducted a workshop titled “Just Caring—Ethical and Policy Challenges: Meeting the Health Needs of the Elderly in Managed Care,” in December for the 11th Annual Symposium on Geriatric Medicine, East Lansing, MI.

**Leonard Fleck** has been appointed chair of the Medicine and Philosophy Committee of the American Philosophical Association for a three-year term beginning July 1.

**Leonard Fleck** chaired the program for the Medicine and Philosophy Committee at the Eastern Division Meetings of the American Philosophical Association in Philadelphia in December. The topic of the session was “The US Supreme Court Opinion on Physician-Assisted Suicide: Critical Philosophical Reflections.”

On March 2 **Howard Brody** will give the Edward B. Cantor Professional Series lecture for the Society of Gynecological Surgeons in Orlando, FL.

On March 10 **Howard Brody** will give a lecture at the College of Medicine, University of Iowa, as part of the inauguration of the Caplan Chair in Medical Humanities.

**Howard Brody** will participate in a panel: “Up Close and Personal: The Physician-Patient Relationship,” at the Cooper Institute, Naples, FL in April.

April 17-18 **Howard Brody** will give the plenary presentation on the topic, “Whose Ethics? Which Medicine?” at the Society for Health and Human Values Spring Conference in Youngstown, OH.

In March **Leonard Fleck** will lead a workshop, “Just Caring: Managed Care Rationing and the Care of the Terminally Ill,” for a conference sponsored by the University of Pennsylvania Health System.

**Leonard Fleck** wrote a chapter, “Ethical Issues in Gene Therapy,” for a book on gene therapy, edited by Thomas Kresina for Fitzgerald Science Press.