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The Ethical Implications of Changing Patterns of Medical Care

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"Organization serves man and rules him, increases his scope and hems him in."
J. W. GARDNER

Medicine involves a complex of relationships grounded in mutual trust and regulated by principles designed to protect the person of the patient. Despite the necessary and increasing intrusion of institutions, health teams, and machines, the personal dimension of medical care will always remain. Any change in the pattern of patient care or in the roles of physician and nurse must, therefore, carry important ethical implications.

Advances in contemporary science, technology, and social structure are creating profound alterations in patterns of medical care. Pressure is mounting for the adaptation of traditional responsibilities so that patients may receive the full benefits of new knowledge. Yet a critical assessment of traditional roles is needed if the new knowledge is to be exploited fully. A better definition of the potentialities of each of the rapidly proliferating health professions awaits whatever realignment of relationships are made in the central triad created by the patient, the nurse, and the physician.

Both medicine and nursing may fear that changes in established patterns of practice will threaten traditional values and ethical standards. But the threat will be greater if the professions do not conscientiously refurbish their functions before the requirements of contemporary knowledge.

ETHICAL CODES OF THE AMA AND ANA

Whenever long-cherished convictions are challenged, a reasonably firm bench mark must be established. The ethical principles and codes of the medical and nursing professions constitute an appropriate base for both evaluation and action. The doctor and the nurse, as well as the public, must re-examine each current and proposed change in the mode of providing medical care. To what extent will the ethical code of each profession modify and be modified by the current demands for revision?

The famed oath of Hippocrates has been the moral standard of western physicians for centuries. In 1847, the first year of its founding, the American Medical Association adopted its first code of medical ethics, patterned on that of Sir Thomas Percival, published in England in 1796.

The current revision of the AMA code was adopted in 1957. It reduces to ten admirably clear and brief paragraphs all the essential principles contained in the former codes. These paragraphs enjoin the physician to merit the confidence of his patient, continually improve his skill, practice scientific medicine, expose the unethical practitioner, uphold the honor of the profession, seek consultation, keep confidential information, charge reasonable fees for services actually rendered by him, and to avoid self-advertising and working in situations which would hamper freedom of judgment.

ETHICS AND ETIQUETTE

These codes, and the more ancient ones from which they derive, are an admixture of ethics and etiquette. Ethics deals with the rights and wrongness of the physician's actions in the light of principles stemming from the nature of man as a person. It establishes normative guides which govern specific situations in such a way that the rights of the patient are always preserved. Professional etiquette, on the other hand, deals with matters arising out of the relations of physicians with each other and with the dignity of the calling.

The public has never found it difficult to understand the truly ethical principles which assure high standards of service and devotion. The proscriptions relating to the conduct of physicians with each other are less clear, and are sometimes erroneously interpreted as self-protective devices. The ban against advertising, the physician's work conditions, the manner of payment, fee-splitting, the courtesies of consultation, and the advancement of public health are not strictly matters of ethics. Their violation may impair the dignity or some of the goals of the profession, but they do not by nature involve usurpation of the human rights of the patient.

The revised code of the American Nurses Association contains the same intermingling of etiquette and ethics. A fair number of its 17 statements are concerned primarily with the dignity and prerogatives of the profession rather than with the rights and duties flowing from the human nature of the patient. For example, being a good citizen, participating in nursing organizations, in legislation, and establishing terms of employment are exemplary ends in themselves but they are independent of the direct duties owed to the patient.

The truly ethical core of the codes of both professions derives from the...
dignity and rights of the patient as a person. This is the criterion against which new arrangements must be measured. Any changes that derogate or compromise these principles are unjustified. The etiquette of the professions, on the other hand, could be altered materially if such changes allowed for better services to the patient.

The code of the AMA says little about interprofessional relationships except to warn against association with anyone who does not practice medicine based on scientific principles. The ANA code is somewhat more specific. It requires the nurses to assume responsibility for both "dependent and independent nursing functions," specifically forbids the delegation of nursing functions to unqualified persons, enjoins harmonious relationship with physicians and other members of the health team, and states that the nurse must not participate in unethical procedures herself and should expose unethical or incompetent conduct of others.

Even on close examination nothing can be found in either code that would countermand a realignment of roles. Rather, each code, devoted as it is to the good of the patient, implicitly imposes on each profession the duty to explore all possible avenues which might improve the technical and personal services rendered the patient.

What are some of the current tendencies in patient care, those in operation and those certain to be expanded as each health profession attempts to adapt to the responsibilities imposed by current advances in biology and medicine?

THE TEAM APPROACH

One adaptation in medical care necessitated by specialization and the need to approach the patient comprehensively is the designation by the much abused term "team." Whatever we choose to call it, the cooperative activity of physician, nurses, and other health professionals is a patient necessity in optimum care today. It is inescapable if the preventive, rehabilitative, and psychosocial dimension of care are to be developed equally with the curative.

There are obvious ethical problems and dangers in any team arrangement. The tendency to diffuse responsibility is great. The competence of a group instead of an individual must be assumed. Tasks must be delegated (possibly nominating) to those most capable of performing them. The difficulties of supervision are in direct proportion to the size of the team; as is the threat to mutual trust. Most important, the person-to-person relationship is threatened.

Yet these difficulties must be overcome, for the physician can no longer care for his patient alone. To satisfy the ethical imperatives of his profession, he today faces new duties. Few would challenge his role as captain of the health care team - as primus inter pares. As such, he has two primary tasks: to bring the highest degree of scientific competence to his task and to develop his skill as a coordinator. He must recognize his limitations, appreciate the skills of others, and be sensitive to his patients' need for services other than his own. On the other hand he is responsible for the competence of those to whom he delegates functions. He should consult his team associates. He must recognize that his role is sometimes primary and sometimes secondary, and that it varies with the phases of the patient's illness.

Nurses, social workers, and other personnel are professionals in their own right. The physician cannot simply control their clinical operations. As the ANA code points out, the nurse is responsible for both "dependent and independent functions." She is obligated to refuse to participate in actions she deems unethical, harmful to the patient, or against his interest. This is true of other members of the health team.

How do we reconcile this fact with the physician's role as coordinator? Obviously he must yield some of his individualism and accept the discipline of a conjoint effort in which he is the leader but without absolute prerogatives. But so, too, must the other health professionals, if the physician-coordinator role is to have real meaning.

DELEGATION OF RESPONSIBILITIES

The nurse, the aide, the technician, and others have recently assumed some of the technical tasks formerly belonging to the exclusive domain of the physician. One of the critical decisions for medicine and nursing is whether this assumption of technical tasks is the best direction in which to expand the role of the nurse. I prefer to consider such functions a limited part of her contribution. She should undertake them only when her training makes her the most competent person to perform them, or when they lead to better rapport with the patient.

Answers to specific ethical questions will depend upon the determinants in each actual situation. What is the physician's responsibility as coordinator as he delegates some of his technical functions? The tasks yielded up must not be regarded simply as prerogatives given to someone else. They are rather divisions of labor required for the good of the patient and made necessary by the complex structure of the hospital.

Any realignment of tasks can be properly decided only by joint discussion; they must also be accepted as the moral responsibility of the person who assumes them. The ethical principles that protect the patient must remain operative.

The nurse or any other member of the health team who assumes technical duties must be held morally responsible for maintaining a high degree of competence in their performance. She must answer to the authority of the institution and to the coordinator for failures. Such failures can no longer be considered as exclusively those of the constituent professions. They are mutually shared and must be mutually considered and dealt with.

This implies the need for mutual criticism. There is an urgent need, deriving from the welfare of the...
whole process of delegation of responsibilities. The usual procedure is to multiply tasks and then find people to perform them. A more fruitful approach would be to look at the tasks themselves in the light of the patient's real needs without regard for who does them now. If we think in terms of functions to be fulfilled rather than professions to be satisfied, the results might be better.

RELATIONS WITH THE HOSPITAL

In the past 50 years physicians and nurses have become increasingly a part of the bureaucratic life of the hospital, with an attendant loss of autonomy. The advantages of this association to the patients are obvious, but there has been insufficient exploration of the ethical principles which should guide physician and nurse in their relations with the hospital and its administrators. Each group avows an interest in the welfare of the patient, but with divergent points of view.

A whole new set of responsibilities and duties derive from this association. As the sociologists have pointed out, the hospital is an important part of the therapeutic milieu. It seriously influences the patient's recovery as well as his acceptance and understanding of illness. The interprofessional relationship within the hospital is a significant factor in its therapeutic function. Each profession should resolve jurisdictional problems or problems of status which adversely affect patient care.

Hospital trustees and administrators, in turn, are charged by society with the legal responsibility for the extent and quality of care provided. They cannot entirely delegate this responsibility to the professional staff. Nor can they morally impede the work of the professional who wants to serve his patient to the fullest possible extent.

A more meaningful interchange between trustees, administration, and staff on the institutional philosophy of patient care, control of its quality, and adequacy to meet community needs is necessary. The hierarchy of values has to be weighed in any situation in which conflicting goals are encountered. The acceptance by medical staffs of institutional policies regarding patient care implies some adjustment of individual practices to those requirements.

The emotional charge of such an interchange can be held in check only by keeping the patient in the center of the picture. He is identifiable to all the participants — and independent of the status, prerogatives, and vested interests of any.

SUMMARY

Nothing in the ethical codes of the nursing professions in any way countermands actual or contemplated changes in the patterns of medical care. Each explicitly enjoins behavior which will serve the patient's welfare and preserve his dignity. Each also includes rules of etiquette which guide relationships between members of the profession and are designed to insure the dignity and integrity of that profession.

Rather than banning reassignment of roles in medical care, each code, by its insistence on the good of the patient, compels each profession to explore fully every possible avenue for improving service even when this means yielding professional prerogatives. Hopefully, the nurse-physician relationship can become an example to all who today are earnestly trying to apply contemporary knowledge to their patients in a personal and competent manner.