
The Voices of Nurses on Ethics Committees

by Cindy Hylton Rushton

Nurses, the largest group of caregivers in hospitals, have been visibly absent from ethics committees. This situation is changing, with nurses becoming more educated and sophisticated in ethical discourse and ethical theory. However, more advances need to be made, with spaces on committees reserved for bedside nurses as well as those in managerial roles. Nurses, who focus on the patient's response to health problems rather than on the diagnosis and treatment of the disease, bring a unique and valuable perspective to ethics committees, one which enhances their efficacy.

Nurses comprise the largest group of direct caregivers in hospitals, have the greatest contact with patients and families and, as patient advocates, have a moral obligation to advance the patient's interests. Historically nurses have been the instigators of ethical discussions about patient treatment and the catalysts for developing institutional responses. Recognizing the unique concerns that arise in nursing practice, some nurses have developed nursing ethics forums (Edwards and Haddad 1988). These forums create opportunities for nurses to examine critically the ethical issues that are not routinely addressed by traditional hospital ethics committees. More recently, hospital accrediting agencies such as JCAHO have recognized the need for mechanisms that assist nurses in addressing ethical concerns within their organizations (JCAHO 1993).

In spite of these advances, however, nurses remain a minority on institutional ethics committees, often with only one or two nurses designated as full members (Levine-Aruff 1989). Several factors account for this. First, the forerunners to contemporary ethics committees were prognosis committees who reviewed and evaluated the physician's interpretation of the patient's diagnosis and prognosis. Premised on a "medical indications model," members of these committees were primarily physicians with expertise in critical care, neuroscience, oncology, and the like, but at times included social workers, attorneys, and theologians. Nurses were visibly absent from the list of recommended members on these committees (Murphy 1989). This may reflect the perceived status of nursing in health care environ-

ments, coupled with a persistent view that the resolution of ethical issues resides with the physician.

Second, guidelines regarding the composition of ethics committees have developed slowly. Currently there is no universal agreement regarding the ideal proportion of members representing different disciplines or perspectives on these committees. Early guidelines attempted to encourage interdisciplinary dialogue and to recognize the complexity and diversity of perspectives that arise in clinical care (President's Commission 1983). Despite interest in developing interdisciplinary committees to focus on the broader ethical concerns that surround patient care, widespread movement to develop such committees remained slow. Interest in forming ethics committees did not intensify until the federal government issued the final Baby Doe regulations. These regulations advocated the establishment of infant care review committees to review decisions about forgoing life-sustaining treatment for newborns (Federal Register 1985).

Third, despite increasing recognition of the importance of interdisciplinary representation, physicians still comprise the largest constituency on ethics committees (Youngner et al. 1983; Levine-Aruff 1989). Nurses'

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under-representation may be attributed in part to the position of ethics committees within the organizational structure. If the ethics committee is comprised of medical staff, the locus of influence is directed toward physicians and membership is likely to be dominated by physicians. In contrast, if the hospital administration, board of directors, or a free-standing committee comprise the ethics committee, the locus of influence does not favor one discipline and the committee will have a more balanced membership. A lack of diversity in the composition of ethics committees may diminish the likelihood of constructive and balanced discussions

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about the impact of ethical decisions and policies on each discipline. Moreover, such an imbalance may result in a narrow moral analysis and the lack of diverse viewpoints that contributes to a robust understanding of the clinical situation.

Fourth, traditionally physicians have analyzed moral problems arising in the health care setting. Nurses have often been excluded from the process of ethical decision making. Despite the fact that morality is not hierarchical in nature, nurses often work in systems that confer authority based on one's position in the institution's professional hierarchy. The tendency to view nurses as subordinates has often undermined their authority and hence their moral agency. Dysfunctional or hostile systems, for example, may even force empowered nurses to conform to the traditional power structure in order to control their behavior.

In spite of these realities, nurses' representation on ethics committees has evolved. Their participation ranges from nurses as leaders or co-chairpersons of institutional committees, to token nurses on physician

dominated committees. In some clinical settings such as home care, nursing homes, and long-term care, nurses have dominated efforts to establish ethics committees. This may be a reflection of greater autonomy and authority in the nurses' clinical practice.

Although the diversity of nurse involvement on ethics committees includes staff nurses, advanced practitioners, educators and administrators, etc., historically nurse managers or advance practitioners have been the designated representatives on ethics committees. This is true particularly when only one or two coveted positions are allocated to an entire nursing service. The advance educational preparation in ethics and leadership skills of these nurses is invaluable to an ethics committee. Limiting membership on a committee to the nursing leadership, however, can have a negative effect. Since the locus of ethical decision making is at the bedside, nurses who are providing daily care to patients may not have a direct voice in the deliberations of the ethics committee. Without adequate representation their unique perspectives become inaudible in the moral discourse (Oddi and Cassidy 1990).

Nurses who participate on ethics committees are becoming more educated and sophisticated in ethical discourse and contemporary ethical theory and analysis (Redman and Cassells 1988). Like representatives from other disciplines, nurses who serve on ethics committees often take academic or intensive ethics courses to enhance their background in ethics. Moreover, nurses' broad educational preparation in nursing science and the humanities contributes to informed treatment decision making and the development of a more comprehensive plan of treatment.

The Nursing Perspective: An Essential Dimension of Ethics Committee Deliberations

Nurses bring a unique and valuable perspective to the moral discourse of ethics committees. The issues nurses face at the bedside are different from those of physicians. The nursing perspective is focused on the patient's responses to health problems rather than on

the diagnosis and treatment of a patient's disease. Moreover, the goal of nursing care is to enable the patient, family, and friends to adjust, each in his or her own way, to the changes in the patient's health (Cooper 1991). Nursing actions maximize the control exerted by patients and those close to them. In this way the nurse advances the patient's sense of personhood, self-worth, and dignity. Nurses help patients and their families find

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unique meaning or purpose in both living and dying, and help them realize goals that promote a meaningful life or death (Rushton and Reigle 1993). This holistic perspective is an essential dimension of the moral analysis. Moreover, nurses are legitimate participants in the ethical discourse because they implement the decisions of others and must preserve their own moral integrity in order to provide quality care to patients and families.

The moral sensitivities of nurses inform the way they interpret the moral dimensions of the cases they encounter in their clinical practice. Nursing is care oriented. From this perspective, nurses' moral judgments are emotional and contextual. In other words, the uniqueness of individuals and the particular dynamics of their relationships are essential components of moral decision making (Rushton and Reigle 1993). Nurses who are skilled in articulating their perspectives as members of ethics committees greatly enrich these deliberations.

Sustained relationships with patients allow nurses to appreciate the patient's unique values and life goals and to experience their pain, suffering, happiness, successes, and disappointments. The uniqueness of the nurse-patient relationship often cultivates discussions

of patient and family understanding and interpretation of the patient's situation. This ideally positions the nurse to address the concerns and values of patients and families. These unique perspectives provide an essential knowledge base for making ethical decisions.

Decisions about treatment cannot be isolated from the context of the lives of patients and their families and the special circumstances of each situation. Nurses often bring an appreciation of the patient's relationships, ones that are significant to his or her care, into the deliberations of an ethics committee. Moreover, valuing the context of the patient's life also means respecting cultural, religious, and social differences by honoring choices and respecting belief systems even when they are contrary to the personal values of others. Articulating a patient's beliefs to an ethics committee deliberation contributes to a fair and non-discriminatory analysis.

Nurses are sensitive to the fact that successful resolution of ethical conflicts demands reciprocal interaction and communication among all who are involved in the care of a patient. Skilled in communication, interpersonal interaction, and negotiation, nurses can be instrumental in facilitating a process for decision making that is inclusive of all members of the moral community and that is built on shared values, moral reasoning, and communal experiences (Ray 1994).

Since the locus of ethical decision making is at the bedside, nurses who provide daily care to patients should have a direct voice in ethics committee deliberations.

Nurses are often the first to recognize the moral tensions that are created at the bedside. Their relationships with patients, families, other health care professionals, and administrators position them to be able to identify ethical issues that require an educational, policy or sys-

tems response. Nurses are trained to look at systems in a holistic manner. Often their perceptions about the clinical realities of both patients and providers can offer essential guidance for the work of ethics committees. Nurses can have an instrumental role in influencing and changing institutional policies that impact on the quality of patient care and on the ethical tenor of the practice environment.

As ethics committees become increasingly involved in policy discussions related to quality care and cost containment, the nursing perspective will need to be amplified. Nurses have a moral mandate to collectively involve themselves in efforts to promote the health needs of society (American Nurses Association 1985, 1991). Nursing goes beyond the individual patient to encompass the interests of groups of patients and society in general (Fowler 1989). This perspective is congruent with an emerging societal consensus that endorses universal access to health care as a national priority. The advocacy initiatives of nurses who serve on ethics committees must, therefore, include activities aimed at giving voice to the unique concerns of the clients served by nurses and in shaping public policy and public opinion about the design of a reformed health care system. A nurse's failure to engage in these discussions and analyses results in inadequate and incomplete evaluation of the issues.

Enhancing Nurse Participation on Ethics Committees

For optimal nurse participation on ethics committees, the tenor of the committee, like the tenor of organizations that support ethical practice, must be based on respect, understanding, caring and fairness (Curtain 1994). Organizational strategies to support nursing participation on ethics committees are summarized in Table 1.

Table 1

Organizational Strategies to Support Nurse Involvement on Ethics Committees

- * Confer commensurate authority and accountability for nursing care
- * Designate proportional and diverse nursing representation on ethics committees (include bedside clinicians, advanced practice nurses, educators, administrators)
- * Develop support systems
 - nurse to nurse support
 - administrative support
- * Develop collaborative interdisciplinary practice
- * Develop interdisciplinary educational forums for ethics
- * Devise standards for accountability
- * Develop policies and practices that support nurses' moral agency
- * Establish mechanisms for dispute resolution
- * Provide unencumbered access to ethics consultation.

Barriers to nurse participation on ethics committees parallel real or perceived barriers to nurse advocacy. The degree of risk associated with nurse advocacy and participation on ethics committees is directly influenced by the norms and culture of the organization in which the nurses practice. An institution's culture can either promote or undermine nurses' moral agency and, therefore, their effectiveness on ethics committees. In institutions where hierarchical decision making, objectivity, efficiency, and traditional power structures are valued, incongruencies may exist between the stated philosophy, values and goals of the organization, and the reality of the workplace. In such environments conflicts related to nurse-physician relationships, institutional policies and practices (particularly those that govern resource allocation and the quality of patient care), professional behaviors of administrators and colleagues, and job security arise (Berger, Severson and Chvatal 1991; Haddad 1993; Oddi and Cassidy 1990; Rushton and Reigle 1993; Solomon, O'Donnell, Jennings et al. 1993).

The status of nurses within organizations and the health care system, their credibility and their legitimate authority directly influence their effectiveness as patient advocates and members of ethics committees (Corley and Raines 1993; Wilkinson 1987, 1988). If practitioners and leaders alike do not endorse the role of nurses as participants in the ethical discourse, their participation on ethics committees will also be severely limited. Nursing representation on ethics committees is a visible affirmation of the nursing administration and hospital leadership's commitment to involving nurses in ethical decision making (Edwards and Haddad 1988).

Nurses must practice in an environment that conveys commensurate authority and accountability for the nursing care they provide. Despite some limitations on their ability to act independently of others, nurses' authority is based on their unique expertise in providing nursing care; they give priority to moral values and then act on them. Accountability for advocacy involves not only those actions undertaken, but those not carried out. Failure to recognize and respond to occasions where advocacy is needed diminishes personal and professional credibility. Nurse members of ethics committees serve an essential role in assisting other nurses to identify, articulate, and reason about the moral concerns that arise in clinical practice. Additionally, they provide support and serve as resources to other nurses to facilitate their exercise of moral agency.

Nurses, physicians, and administrators must share responsibility for formulating policies and practices that support the role of nurses as patient advocates and provide a mechanism for dispute resolution. For example, policies that define the scope of professional responsibility for participating in ethically objectionable situations can help nurses preserve their integrity in ethically challenging circumstances. Moreover, fostering an environment in which nurses are encouraged to address ethical issues enhances ethics committee effectiveness (Levine-Ariff and Groh 1990). When conflicts arise nurses should be empowered to enlist the support of others and should be guided about how to work within their organizational framework to address their con-

cerns. Nurses must therefore have direct access to ethics consultants and to ethics committee consultation in order to be effective patient advocates.

Nurses must be the catalysts for creating an environment in which advocacy is expected and rewarded rather than punished and suppressed. Strengthening the support nurses give one another is one avenue for enhancing advocacy (Wlody 1994). Often nurse members of ethics committees assist other nurses to advocate for basic values, rights and beliefs of their patients. Nurses who serve as advocates may find themselves in conflict with the patient, the patient's family, other members of the health care team, or the institutions where they work. In some cases nurses have been accused of insubordination and suffered loss of reputation, license, friends and self-esteem. Those who act alone and without the benefit of an organized problem-solving process seem to be at higher risk (24). Participation on ethics committees offers nurses an important avenue for reducing these risks.

Conclusion

Ethics committees have evolved from merely prognosis committees to diverse interdisciplinary forums where ethical conflicts are systematically analyzed and reasoned recommendations are made. New models of ethics committees now need to be developed and evaluated. As these models emerge, nursing representation must be broadened to include more bedside practitioners, advanced practice nurses, educators and administrators. Increasing nursing membership will also serve to broaden the perspective of ethics committee deliberations and address obvious gender imbalances. Nurses who have participated in the evolution of ethics committees to date must now provide the necessary leadership to propel the next generation of ethics committees to new levels of diversity and accountability.

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THE FAR SIDE

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