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Ethics in Nursing Administration

A Framework for Analysis, Part I

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A COMMON SCENARIO

About 10:30 PM *on November 12, John Doe* was admitted with irregular breathing and heart rate to the emergency department (ED) of a large teaching hospital. Various diagnostic tests were done. At about 2:00* AM *on November 13, Doe went into respiratory arrest and was intubated and ventilated manually. Dr Jones* decided to admit Doe to the intensive care unit (ICU) stat, and called the ICU to advise the nursing staff of the admission. The nurse who took the call said, "Dr Jones,* we are very busy. We need more help if we are to admit another patient. Do you want to call the night supervisor, or should I?" Dr Jones indicated that he wanted the ICU nurse to call the supervisor and let him know what she said. Meanwhile, Dr Jones* called Dr Smith*, the intensivist on call, to apprise him of the patient's condition and his need to admit him stat. The ICU had been understaffed for more than 6 months.*

The ICU nurse called the supervisor and apprised her of the new admit—who also was a ventilator patient—and of the need for more nurses in the ICU before this patient could be safely admitted. The supervisor told her to "do the best you can" and promised to call the ED to see if they could care for the patient until the day shift arrived. She did so, and Dr Jones made it clear that ED could not adequately care for this patient. The nursing supervisor responded that if Jones admitted Doe*, he would have to be responsible for his care; this remark seriously aggravated Jones* who hung up and called Dr Smith* again to tell him that the nurses were giving him a hard time and he needed Smith's* help getting care for this patient. Smith called the ICU and reprimanded the nurse who answered the telephone for giving Jones* flack about admitting John Doe: she did not know what he was talking about and assured him that no one was giving Jones* any flack. She did, however, tell him that ICU was at the saturation point and could not take any more patients until they got more help. Smith* called the nursing supervisor and told her that Doe was being admitted to ICU, and he expected more staff would be there as soon as possible.*

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At 5:20 AM, Doe was escorted to the ICU by an ED nurse, Dr Jones, and Dr Smith who transferred Doe to the one empty bed. However, when the nurse attempted to give report to one of the ICU nurses, she refused to take it, as there was an emergency situation she had to attend to with one of her existing patients. The room Doe* was admitted to was not equipped for his care, and the 2 physicians attempted to assemble the necessary equipment with the occasional help of one or the other of the ICU nurses—who did, in fact, appear to be swamped. The physicians were angry and overwhelmed. The nurses were angry and overwhelmed. And John Doe was desperately ill. Later in the day, all 3 registered nurses on duty in the ICU were suspended without pay for 3 days for insubordination...*

PHILOSOPHICAL FRAMEWORK

The ethos of the nursing profession today have been shaped largely by the moral climate of our educational and clinical institutions. Although these institutions traditionally have positioned themselves to the community at large on utilitarian grounds, their interior values often reflected an attempt to remain aloof from questions of ethics. The rationale for this position was that ethical norms and value judgments are purely subjective and emotive, thus, they have no place in the classroom or in the work environment (which prides itself in outcomes through task mastery). Consequently, the institutional matrices that shaped the profession tended to exclude explicit questions of ethics from their respective domains. The current healthcare environment is changing rapidly, begging the question of the appropriateness of a purely utilitarian model. New regulations impose expectations on the professional nurse to not only be a master of clinical skills but also to protect that patient's best interest through a focus on safety and quality. Conflicts erupt daily on our clinical units.

The impact of this state of affairs on the profession and the professional has been a growing sense of confusion, frustration, indifference, apathy, and anomie—in that order of development.

To a certain extent, the difficulty surrounding the subject of this morale debate is largely a misunderstanding about words that often are used as if they were synonymous, when, in fact, they have different meanings—specifically, the word "morals," "values," and "ethics." An understanding of each concept and its application will serve as a guide to nursing leaders in beginning to address the debate.

Values refer to the fundamentally important matters that shape one's life. Each human being defines himself in terms of the value choices he has made, and each has a value system.

Values (or the attaching of importance to someone or something) arise from the experience one has gained from observation of the world and from interactions with other living beings. In this sense, the values one holds may be both personal and shared with others.

The word "morals," on the other hand, refers to the degree of congruity between a particular choice or action and a person's perceptions of moral values and ethical norms. Put quite simply, a moral person is one who acts in accord with the dictates of his conscience. Conversely, an immoral person is one who deliberately chooses to do what he sincerely believes to be wrong.

The term "ethics," however, refers to an organized analysis of the rightness or wrongness of an action on the basis of roles assumed, commitments made, and/or the results that a particular choice or action has on the lives and well-being of others. Unless human beings live totally isolated from each other—more or less as hermits—they necessarily are concerned with their own actions and the actions of others in so far as these actions (1) impinge on their own welfare and that of significant others, (2) affect the actions and reactions of other human beings, and (3) produce consequences in the world. In short, human interdependence imposes conditions that compel individuals to judge the rightness or wrongness of actions.

In the case of both values and morals, no one outside the person can know for sure what are his values or whether he has acted in accord with his values. However, in the case of ethics, someone outside the person can know whether he has fulfilled his obligations according to his role and station *in* life and whether he has fulfilled his commitments. Someone outside the person also can know and judge the effects a person's choice or action has had on others. In this sense, the discipline of ethics is objective rather than subjective; it judges actions, not the human beings who perform them. Being nonjudgmental, then, means that one does not presume to judge the moral worth of another person; it does not mean that one does not make any judgments. People can and must judge the moral worth and impact of actions—their own and others.

As both nurses and administrators, executive nurses must be concerned about both nursing ethics and business ethics. These two are not inimical—in *A Christmas Carol*, Charles Dickens had the ghost of Christopher Morley say, "Business! Mankind was my business; charity, mercy, forbearance and benevolence were all my business. The dealings of my trade were but a drop of water *in* the comprehensive ocean of my business." But they produce different perspectives that, in some cases, lead to different conclusions.

Even though ethical concerns of managers do not vary significantly from those of their employees, including nurses, the focus and scope of these concerns are different. A staff nurse *is* concerned with the efficient, effective, and humane delivery of nursing services to a specific patient or to a limited group of patients. Therefore, the staff nurse must work diligently to obtain all services and resources necessary to maximize benefits for this particular patient or group of patients. That *is* part of a nurse's role as patient advocate. A nursing administrator *is also* concerned with the efficient, effective, and humane delivery of nursing services, but to *all* patients in an institution. Both perspectives are essential: the needs of the many, the needs of the one. Thus, while staff nurses make judgments on the basis of the demands of individual justice, the nursing administrator makes judgments on the basis of the demands of distributive justice. Perelman enumerates 6 approaches to the demands of distributive justice: (1) to each the same thing; (2) to each according to his works; (3) to each according to his merits; (4) to each according to his rank; (5) to each according to his legal entitlement; and (6) to each according to his needs. Depending upon the specific circumstances, one or the other of these approaches will take precedence in a decision. Whether the problem involves personnel or patients, staffing, or distribution of material resources, these approaches can offer guidance and structure to decision making. Although each of these approaches can be helpful to nursing administrators as they approach difficult problems, these also have pitfalls and limited applicability. Briefly, each approach embodies different values and entails different sets of presuppositions that lead to different actions—some of which might be unjust in some circumstances.

1. *Justice renders to each the same thing.* This approach requires that all people be treated the same way without regard to distinguishing particulars. Although such an approach might be helpful in certain decisions, the ill have different problems and levels of illness, and some of these problems and needs are more compelling than others. For example, if we accept the case for people's rights to equal access to healthcare services, we also know that such services are not unlimited and it seems only fair to differentiate according to the acuity of illness and basic need for care. Thus, hospital policies allow for triage in an ED, and decisions regarding admissions are not based solely on a first-come-first-served basis.
2. *Justice renders to each according to his works.* This approach does not require equal treatment, but rather proportional treatment according to a person's professional or social utility. It ignores concerns for merit or for need. These

obvious inequities do not destroy the usefulness of this approach in reaching other decisions (ie, the formulation of emergency contingency plans in the event of terror attacks or natural disasters), but they do highlight the need for judgment and discernment in its use.

3. *Justice renders to each according to his merits.* This approach to justice does not demand universal equality either; rather, it bases decisions according to a criterion of personal excellence. Its use may be appropriate in some areas (merit raises, promotions, awards), but its applicability in decisions regarding distribution of institutional resources is quite limited.
4. *Justice renders to each according to his rank.* Again, such an approach does not require equality in all things, but it presupposes that rank "has its privileges." While it might be quite fair to base salary ranges on education and experience, it may be unfair or even foolish to base other decisions on such a criterion. In the realm of patient care, it would infer that some patients are more "worthy" of service than others because of social status, income, and health habits, or payer status.
5. *Justice renders to each according to his legal entitlement.* This approach requires that all persons be accorded their rights under the law and under legally binding contracts. It is not particularly helpful when the legal entitlements of one person or group are in conflict with the legal entitlements of another person or group. Although it does have the force of legal sanctions behind it and thus is likely to be the final arbiter in some decisions, it should not be confused with what is right or just. Unfortunately, many decisions that face healthcare administrators and many of the laws and requirements involve conflicts of legal rights that are not remedied quite so easily.
6. *Justice renders to each according to his need.* This formulation may come closest to meeting the demands of justice in the allocation of institutional resources for patient care. That is, it is fair to allocate resources according to patient needs. However, its utility in personnel matters is limited. While it might be quite just to allocate the institution's educational resources to the personnel in greatest need of education, *it* would be unjust to promote a person merely on the basis of personal need.

Although an understanding of the principle and approaches to distributive justice are most helpful to staff nurses as they struggle to set priorities in clinical practice, it is absolutely essential for nurses in management or administrative positions. For example, a staff nurse has an obligation to request more help when staffing on her unit is inadequate and has a right to expect a response from administration. She need not be concerned about the staffing on other units. The nurse administrator, however, must judge the conflicting needs of other units to determine which has the greater need and allocate staff accordingly. She has an obligation not to base decisions on who complains the loudest, but rather on a fair assessment of needs. Such decisions do not deny the needs of the one, but rather recognize the greater need of the other.

Such differences in perspective can lead to conflicts, particularly if there is no understanding of one another's legitimate roles and concerns. These conflicts can be minimized if, in the sorting out of priorities and ethical quandaries posed by conflicting claims and needs, nursing administrators ask themselves the following questions:

1. What *is* the case? That *is,* how much factual information is available about this situation, *issue,* or conflict? Which needs are the greatest? Why?
2. What criteria should be used to make this decision? Is it essentially a nursing decision? An administrative decision? Is the problem involved essentially one of policy?

3. In this particular instance, who is best qualified to make a decision—the staff nurse(s), nursing management group, physicians, administrative council?
4. Is this decision,' in fact, a group decision? That is, how should the decision be made, individually or collectively?

If it is a collective decision, all involved should be aware of several characteristics of group decisions and the group participants' responsibilities in making such decisions. In general, participation in group decisions obliges one to submit to the ultimate authority of the group. There are, of course, exceptions to this obligation the exegesis of which is not the subject of this article. Generally, when individuals consent to participation in groups, they assume accountability both to the group and for the group. That is, as a group member, a person can be called upon to answer to the group for any actions he or she may take that will affect the group. Moreover, as a member of a group, a person is answerable for all actions taken by that group (to the individual(s) most affected by a group decision, to the institution or agency, possibly to statutory bodies, and perhaps to society at large).

No group member is absolutely autonomous: the self cannot be permitted "to hold sway" because the group's decisions and actions affect more than the self. In addition, participation in a group requires a person to voluntarily assume accountability to someone or something other than the self. However, because the individual also has assumed accountability for the group, he or she must exercise the responsibilities of freedom within the legitimate structures provided. Therefore, in some instances, it may be necessary for a group member to oppose a group decision. Although noncompliance is not the right of any group member, it may be a duty. The burden of proof, however, lies with the dissenter.

5. A fifth question to be asked is, who should benefit the most from a particular decision—patients, staff, families, the institution? While ideally, all should benefit, the unfortunate reality is that sometimes a decision must be made at the expense of the others, or, at the very least, a decision may maximize benefits to only one of these groups. As examples, a decision to raise salaries could be seen by some as not in the best interests of patients and families who may have to pay higher charges, or a decision to keep a cancer screening program open may not benefit the institution in terms of income generated and losses absorbed. In such instances, it is most helpful to determine which group(s) ought to benefit or benefit the most from this particular decision in this particular instance.
6. How should the decision be implemented? It is one thing to reach a decision and quite another to determine how it can or should be implemented. One major administrative responsibility is to ask and to answer this question. When faced with ethical problems or *issues,* the nursing administrators' priorities differ from clinicians' not only in scope but also in breadth or inclusiveness. That *is,* the administrator also must place high priority on the well-being of other employees and on the welfare of the institution itself—not usually areas of high priority for staff nurses. Nursing administrators have very specific responsibilities to the public, to the staff he or she employs, and to the profession that differ both quantitatively and qualitatively from those of bedside nurses. Both the practitioner and the administrator must fulfill the commitments or promises of the profession, but the manner in which these obligations are met directly reflects the different roles they fill.

Part II of this column will appear in the next issue of *Nursing Administration Quarterly.*