Part I of this two-part feature on bioethics defined medical ethics and explored the growing popular interest in this branch of philosophy. In Part II, the author develops guidelines for specific decision-making by nurse anesthetists.

Compared to colleagues in other branches of nursing, the nurse anesthetist is a more independent practitioner—more an agent of the physician than an aide or an assistant. But, traditionally it has been the physician who has had primary legal responsibilities for the patient, and the anesthetist, in practice, has been expected to carry out the physician’s orders rather than to take independent initiatives. This is so even when there are no anesthesiologists overseeing the case.

Dependence on and deference to the physician are reflected in the education of anesthetists and in reviews of their performance by Professional Standards Review Organizations (PSROs). The fact that the anesthetist is oftentimes an employee of the hospital further reduces opportunities for independent professional initiatives and intensifies the expectation of obedience both to institutional supervisors and to physicians. The “good” anesthetist is one who follows policies and orders which he or she had little influence in formulating. Can such a standard of “goodness” be reconciled with professional ethical conduct? Can the “good” anesthetist as determined by the physician or the hospital administrator be an ethical professional person?

The CRNA’s situation

There is no disagreement about the fact that the nurse anesthetist has many responsibilities. He or she is responsible for tasks, operations, areas of the hospital and in many cases, for other employees. Corresponding to extensive responsibility, however, there is little autonomy in the sense of a capacity to take independent initiatives. There are not many opportunities for autonomous emprincipled behavior in the sense of action taken independently and in compliance with internalized principles which have the support of professional standards. Ethical principles may come either from one’s own professional tradition or from the broader Western ethical tradition or both. But where emprincipled action is called for, a dilemma usually ensues in the form of the clash between the anesthetist’s autonomous behavior and the requirement of loyalty to superiors. It is in this sense that the very possibility of the anesthetist being ethical can be questioned.

Independent ethical action on the part of anesthetists is complicated both by their place in the social structure of the hospital and by their relationship to physicians whose orders they are expected to carry out. Anesthetists are not usually the primary decision-makers, and disagreement or conflicts with superiors add another dimension to the problem of emprincipled action. Even when the welfare of the patient (for whom the nurse anesthetist is ethically accountable) is at stake, emprincipled independent action is difficult to take. The structure of the hospital makes its own demands on the anesthetist who is an employee of that institution, and these do not always correspond to the needs of the patient. In fact, they may make proper care of the patient impossible.

Role and image diffusion

The role of the nurse is obviously in the midst of a change. The traditional role of an employee subservient to physician and institution is
under siege both from individuals and professional associations. After a very long history as a profession, the American Nurses' Association finally approved a code in 1950—an important first step toward a more independent and autonomous professional identity. In the international code of nursing ethics, both the historical subservient image and the more modern independent one are combined in a single section which reads, "The nurse is under obligation to carry out the physician's orders intelligently and loyally and to refuse to participate in unethical procedures." (Section 7.)

But how does the nurse do both? When there is a conflict between loyalty or obedience to the physician and emprincipled independent action, which comes first? A more recent code adopted by the ANA in 1976 is less ambiguous in stipulating that the nurse's primary responsibility is to patient care and safety (Section 3). But still the dual responsibility and its dilemmas are built into the very structure of nursing.

Collaboration is one term which is used to reflect the emerging image of the modern nurse. Collaboration, however, rather than obedience, depends upon strong professional support and well defined areas of authority. It assumes a more equal and more respectful relationship between the anesthetist and the physician that is still more an ideal than a reality. Attempts to change the present situation have contributed to serious interprofessional conflict between anesthetists and physicians. As nurses move to more independence and control over both education and professional behavior, physician-based power centers feel threatened and react defensively. A better relationship down the road seems to require, for now, enduring the pains of change in the present system. Without this change the anesthetist simply cannot be ethical. Unless ethics is reduced to a slave morality in which obedience is the only standard of goodness, the anesthetist in most hospital settings is in an ethical "no-man's land."

To change this situation means to gain access to centers of power on national, state, and local levels. The establishment of clear definitions of role and more specific standards of behavior within the profession is also necessary. Anesthetists need access to policy-making bodies in order to make certain that their perspectives on policies and professional needs are heard and recognized. And then, from within the profession, ethical standards must be developed which set out clearly both the responsibilities of anesthetists and their relationship to patients. When this has been accomplished, the anesthetist will have ground upon which to stand. Only then can the anesthetist be ethical in the sense of being capable of taking independent emprincipled initiatives.

In the meanwhile, however, there are many ethical conflicts to be faced and painful dilemmas to be wrestled with. People cannot wait until all issues of justice are resolved before living their lives, and anesthetists are no exception to this rule. The question is how to be just and do right in the present, less-than-ideal situation.

The cases presented me by nurse anesthesia students ask what to do now, not later when the lines of authority and relationships have changed. One nurse anesthesia student wrote to me and articulated the dilemma of the anesthetist with unusual clarity:

"I have perceived a need for a sense of clarification or direction in dealing with issues which may present moral or ethical dilemmas to the anesthetist. The problem as I see it stems from the fact that anesthetists are ancillary professionals which places us in a secondary role no matter how well academically or experientially qualified we are and despite any degree of independence of practice we have attained."

**Ethical decision-making in the midst of disagreement**

Almost anything about a medical case can be the cause of disagreement and conflict. The medical facts of a case, for example, can cause serious disagreement. The anesthetist may be highly qualified in certain areas and disagree with the physician on medical diagnosis, treatment, risks, benefits and prognosis. The same is true of the human facts such as the significance of the patient's age or willingness to undergo a procedure. Disagreement about either set of facts may create a very thorny problem. Good communication can sometimes close a gap of disagreement or at least create an agreement to disagree. But at other times, disagreement about medical or human facts leads to very different ideas about right and wrong ways of treating the patient.

The major potential for disagreement, however, is in the area of values. The anesthetist, for example, may have strong convictions about the rights of patients and about his or her obligations to protect these rights. A physician, on the other hand, may believe the primary value consideration is what he thinks "is best for the patient." For a physician, truth-telling may not be an important value; but it may be very important for the nurse.

The anesthetist, coming from a background
in the nursing tradition, may feel his or her primary responsibility to be the care and protection of the patient. Thus, the anesthetist can come into conflict with a physician whose main interest may be in advancing medical knowledge. If the physician is interested in developing his own skills, in research, or in the health of patients in general rather than in a particular individual's health, then a value conflict with the nurse anesthetist can be even more pronounced. In such cases we have a real ethical disagreement and possibly an ethical dilemma.

With full recognition of added difficulties related to role, image, hospital structure and relationship to doctors, we can take a closer look at the case provided by students in Part I.

A case example

A surgeon who has a reputation as a "hustler" wants to place a feeding gastrostomy tube in a 94-year-old woman with terminal cancer who, following preoperative physical evaluation, is determined to be a physical status 5. Let us look at three possible interpretations of this case.

Scenario 1. If the 94-year-old terminal patient's condition is such that the feeding gastrostomy tube would be no help to the patient, then it is medically not indicated and ethically wrong to subject a patient to a useless procedure. To do so is to take advantage of a helpless person for personal advantage and this is a serious violation of one of the core principles of medical ethics: Do no harm.

The fact that the woman is terminal does not mean that no treatment at all would ever be ethically indicated. Procedures which would help her condition, extend her life, and improve her functioning would be ethical as long as the patient is properly informed and consents to them. If, however, the terminal patient is actually in the dying process, then the medical intervention may be an experiment on the patient or an extension of the dying process. In both cases, the intervention would be wrong.

The ethically proper thing to do in this case is closely tied to understanding the medical status of the patient. The dying process, by definition, means that there is no real medical remedy; and therefore, the ethical thing to do is not to treat. When the patient is dying, curing should give way to nursing by providing pain relief and personal attention. If aggressive treatment continues for ignoble motives such as greed or even noble motives such as scientific progress, the nurse anesthetist cannot simply stand by and close his or her eyes to what is going on. To take the attitude: "It is not my responsibility" or "I'm just following orders" brings a person dangerously close to those who carried out experiments in Germany during the 1930s.

Scenario 2. Let us suppose that the anesthetist is doing the preoperative examination and the patient indicates that she does not understand what is happening. And, suppose that the surgeon has told the patient that without the surgery, she will surely die and has ordered the anesthetist not to provide the patient with any information about the procedure. If the patient is actually dying and the anesthetist is aware of a lack of consent or lack of informed consent, then there are legal as well as ethical violations involved. It could be that there are grounds for malpractice on the basis of fraud (an intentional tort rather than a simple negligence). Any involvement on the part of the anesthetist in such a procedure would constitute a crime as well as an ethical wrong.

Scenario 3. Finally, let us suppose not the worst, but the best scenario: The patient is terminal but not dying and in fact would greatly benefit from the surgery. The surgeon's direction to provide very little information prior to consent originates in a concern for what he thinks is best for the patient and a conviction that the patient would be harmed by providing too many worrisome details about the procedure. The surgeon may be operating with beneficence (the good of the patient) as his highest value and relying on a therapeutic privilege to reduce the demands for informed consent.

On the other hand, the anesthetist may give highest priority to the patient's right to give or refuse consent to treatment and a corresponding right to know as much as possible about what is being done to her body. If there is any question about the patient's competence, the anesthetist may believe the closest family member should be informed and give consent. The physician, however, may believe that he should supply the needed consent. Now there is an ethical conflict between the anesthetist and the physician and an ethical dilemma in the sense that if one value (beneficence) is acted upon, another value (patient autonomy) is violated. Now what?

If the anesthetist cares about the efficient functioning of the health delivery system and considers that, as presently organized, it does more good than harm, then his or her behavior would have to take the system and its functioning into
consideration in trying to decide the right thing to do. If loyalty to the physician and following orders have a value and contribute to the functioning of a valued system of health care, then disobedience may cause some harmful effects even when it is called for, indeed required, by the CRNA's ethical code and personal principles. It is exactly this ever-present dilemma which makes independent ethical initiatives on the part of the anesthetist so difficult.

If the anesthetist sees no value in the system or in the traditional rules and principles of the nursing tradition, then there would be no ethical restraint on taking whatever action is believed to be right, no matter what disruption follows. But, such an anesthetist, indeed, such an individual, is a rarity. The system makes it impossible for such a person to survive. No system will support revolutionary action against itself; and besides, most anesthetists are not revolutionaries. They have some feeling for the health care system and perhaps for the principles and perspectives of the physician as well. But, who is the patient's advocate? In surgery, is it the anesthetist? Is there any consideration being given to the values and principles which are basic to the nursing profession? Does the anesthetist have strong feelings about the patient’s treatment? If so, does anyone care about these feelings?

**Justifying an ethical choice**

Finding a way out of a moral dilemma is by definition impossible, and yet some decision must be made. When one or another course of action is chosen, it must be accompanied by a justification for the decision. Specifically for the anesthetist, the dilemma may take the following form: "If what I believe to be right and proper for the patient differs from what I am ordered to do by a health professional of higher rank, and I place some value on acting within the system, how can I justify my decision to act or not to act?" Another way of formulating the dilemma is to ask when disobedience which causes disruption and conflict can be justified.

Thinking through this dilemma requires that one concentrate on basic principles of Western ethics and on the core principles of medical ethics. Core principles, per se, are those standards which are at the heart of the ethical tradition and on which the very system of Western medicine is founded. By comparison with the political system, the core principles of medical ethics would be analogous to basic constitutional rights. They are the standards which transcend individual differences within a tradition, the action guidelines which all right-minded persons purportedly respect. Widespread violation of these standards would cause an undermining of the system itself because the core principles constitute the commonly shared standards on which basic relationships depend.

The core principles, then, are distinguished from other rules or standards which one person may hold as important to his or her particular ethical stance or important to a particular segment of society. If an appeal is made to the core principles, it would be much stronger than a similar appeal to a person's particular moral standards or personal ethical preferences. A disagreement between physician and anesthetist over individual moral judgments is serious enough, but is in a different class from a conflict which centers around the violation of a universally recognized core principle.

In cases where a core principle is involved, disobedience to orders may be recommended and indeed may be the only morally right thing to do. Given the fact that core principles are shared by all medical professionals, any order to violate them could not be justified because such an act would violate standards with which all parties are in agreement and which are the very foundation on which good medical care is built.

What are these core principles? They may be different principles or different versions of one principle: Do not take advantage of the helpless position of a patient; do not use patients as a means or treat them as things; do not harm the patient or cause harm for which there is no compensating benefit. There may be disagreements about how the core principles are applied, but not about the principles themselves. Where there is a flagrant violation of core principles, the anesthetist would be expected to make an ethical protest and perhaps to withdraw from the case if the protest is not heeded.

There are many other principles and rules derived from the core principles, and disagreement about these can also cause painful dilemmas for the anesthetist. Principles of the Western medical tradition, like informed consent and beneficence, are close to the inviolable core principles and therefore, are close to being themselves inviolable. Where one party in a case consciously or unconsciously violates these second-level principles, he or she comes close to undermining commonly shared standards on which the system depends. Consequently, cooperation in a flagrant
violation of derived principles may have to be withheld.

If principles and rules of lower rank are being violated and cooperation is ordered, then a delicate judgment will have to be made which balances the wrong being done to the harm that will result to oneself and to the system. There is some balancing that goes on in most moral judgments, and this should not be thought of as strange or unusual. (A clear choice between good and evil is characteristic of children's fairy tales and class B movies.) The consequence of one or the other course of action as well as alternative actions have to be considered as carefully as possible (realizing that no one is an expert on the future). And another factor has to be considered: Institutions like modern medicine, not unlike other institutions of our culture, depend for their survival on the seriousness with which participants approach ethical questions.

**Ethical guidelines for anesthetists**

While it is never possible to set out answers to particular problems before they present themselves, some general guidelines can be developed from experience with similar, if not exactly the same kind of problems. These can be divided into two groups: *Normative guidelines* which provide direction in deciding what is the right or wrong thing to do, and *procedural guidelines* which offer help in proceeding with the decision.

What follows is an attempt to formulate such guidelines for anesthetists in a tentative and suggestive way. Anesthetists themselves will be the best source for developing more definitive standards because they are the primary ethicists for their profession. We will look at suggested procedural guidelines first.

**Procedural guidelines**

1. If you are put in a position which requires refusal of cooperation with all the possible harm attendant thereto, then the refusal should be limited to the specific instance of significant violation of core principles and not turned into a widespread disruption.

2. In cases of doubt about the ethics of a particular procedure, the anesthetist may presume that basic ethical standards have been met (such as informed consent), unless there is clear evidence to the contrary.

3. When a significant ethical violation is discovered only after a surgical procedure has been started, then cooperation can continue in order to avoid an even worse harm.

4. Before refusing to comply with an order or to cooperate with a surgical procedure, an attempt should be made to discuss the issue with the professional person primarily responsible for the case and to make clear the reasons why disobedience or refusal of cooperation is considered ethically required.

5. If a personal and direct appeal is not effective, then help should be sought from other persons, preferably professional peers, who may have enough influence with the primary decision-makers to bring about a modification of behavior.

6. If all else fails, and if time permits, help should be sought from someone in authority over the primary decision-maker.

These procedural guidelines reflect caution and assume that not every instance of refusal to follow orders is justified. Effective health delivery, especially in a surgical setting, requires a system which makes possible deliberate action, and consequently, some pattern of authority. Committee meetings and democratic discussions in most situations are out of the question. The recognized authority must be able to take quick action when it is called for, and other members of the team have to be counted on to cooperate. Consequently, refusal to cooperate may itself constitute a violation of principles if in an emergency setting innocent parties may be harmed. Not every act of disobedience, then, can be justified.

One other underlying assumption is contained in these procedural guidelines: the distinction between *may* and *must*. It is all too easy for an ethicist who is not in the situation of nurse anesthetists to indicate what must or should be done. But in the case of anesthetists refusing to cooperate with a surgical procedure for ethical reasons, tremendous personal sacrifice is usually involved. Jobs can be lost, reputations ruined, and future survival threatened.

Emprincipled action in the form of refusal to comply with a directive because it violates an ethical norm or principle is not a casual matter for a nurse anesthetist. Indeed, it may be a heroic act, and heroism cannot be obligatory for a whole group of professionals. Refusal to cooperate, then, may be duty, but one which some particular individuals are unable to fulfill. Until nurses generally and the nurse anesthetist in particular have more autonomy as a profession, stronger peer support, and better defined authority, not everyone can be obliged to do what is best.

But, neither are compliance and cooperation
always justified. If the anesthetist believes that what is going on is not only a violation of the core principles of medical ethics, but that the system itself is promoting such wrongs, then a more radical response may be called for. Systems can become corrupt and deteriorate beyond the point where evolutionary improvement is possible. In such cases, a more revolutionary ethic is appropriate and more radical confrontational activity justified. However, no one should rush into revolution. The nature of the situation must be carefully analyzed and caution exercised to prevent deep-seated personal dislikes and resentments from being converted into convictions about the corruption of the whole system. No anesthetist alone can assume individual responsibility for the reform of American health care. Confrontation and disruptive refusal must, however, at least be mentioned as a possible form of ethical response.

The toughest ethical questions may be about how to proceed. The procedure under consideration may be such an obvious violation of core ethical principles that resistance is obviously called for, and the question is how to go about refusing to cooperate. In an extreme situation, such as the worst case scenario of the student's example presented earlier, the question is how to confront the surgeon or perhaps how to warn a patient on whom useless, harmful and unconsented-to surgery is planned.

If the anesthetist is requested to get a signed consent from a patient who is not informed, then refusal is necessary. Carrying out the decision not to cooperate is difficult, but made somewhat easier by the realization that the action is both legally and ethically wrong. Cooperation in this worst scenario situation would be a knowing involvement in a crime.

**Normative guidelines: An ethic of cooperation**

But the issue of cooperation is more complicated in less clear-cut cases. In the most flagrant cases of fraud or patient abuse, the ethical thing to do is strongly encouraged by legal sanctions. In less flagrant cases, however, the matter of cooperation is more difficult to decide. The circumstances of the case must be given very close attention because right and wrong in ethics generally as well as in medical ethics are closely dependent upon circumstances. The ethical anesthetist cannot be excused from gathering facts, weighing alternatives and foreseeing consequences.

Generalizations from long moral experience which have been synthesized into ethical principles recognized by society must also be judiciously applied to particular cases. Core principles of medical ethics like "do not harm the patient" are closely related to more general principles of societal ethics such as justice, autonomy, and care. Beneficence, or caring for the patient, is a particular form of love. Respect for freedom is both a medical principle and a principle of the broader societal ethic. The same is true of justice and equality. The anesthetist who is faithful to the core principles of ethical medicine is at the same time faithful to the standards of a broader Judeo-Christian ethic.

But the weighing of circumstances and the application of principles must finally point to a decision about whether or not to cooperate in a particular case. There is something about this decision which is a matter of individual prudential judgment. At some point the abstract standards and factual analysis must be reduced to the choice of an appropriate response in this situation. Before moving to this individual choice, however, there are a few more specific action guidelines that may be used to help the anesthetist make both a prudential and a defensible choice.

1. It is always wrong to cooperate with an evil action by intending the evil oneself. Intentional cooperation in the evil is wrong even when the standards being violated are not basic principles.

2. If the wrong being done is a violation of a core or basic principle (such as unnecessarily exposing a helpless patient to serious harm, or endangering a patient's life without possible benefit, or committing fraud against a patient), if the wrong cannot be done without the anesthetist's cooperation, and if the anesthetist does not stand to suffer gravely for refusal to comply, then cooperation should be denied.

3. If the ethical wrong is a violation of a lower-order rule and the wrong being perpetrated is not serious (for example, the removal of an appendix which the patient can be presumed to consent to if it were possible), if the wrong will be done even if the anesthetist's cooperation is withheld, and if the anesthetist stands to suffer grave personal disadvantage by refusal, then the anesthetist's cooperation is not unethical.

Several considerations provide justification for these guidelines; the most important one is that the action of the anesthetist is not itself evil or wrong. Administering an anesthetic is not a wrongful act. It is the surgery in the case we are considering that may be wrong, and the anesthetic is connected to that wrong only circumstantially.
If the anesthetist neither causes the evil nor intends any evil to the patient, then neither the action of the anesthetist nor the anesthetist's intention can be said to be wrong.

There is no denying, however, that what the anesthetist does can constitute cooperation in another person's wrongful act. The central concern, then, is an ethical evaluation of cooperation; that is to say, deciding when it is justifiable and when it is not. Cooperation means an involvement in evil and correspondingly, constitutes some responsibility for it.

If the anesthetist decides to cooperate, the wrong which he or she does could be mitigated by any one of the following circumstances: The obligation to cooperate by contract and condition of employment; the obligation of maintaining good working relationships with surgeons and other team professionals; the degree of personal harm which can result from refusal of cooperation; the possible harm to the system of health care delivery by instances of disruption; the remoteness of the anesthetist's action from the wrong done; and/or a certain good achieved through cooperation which may outweigh the evil.

Human beings do not live in a pure or perfect world, and the anesthetist does not work in a pure and perfect system. Some cooperation, however, is necessary in both cases—the alternative is to stand apart from life. If the case is not one of flagrant violation of a core principle, then there is usually another ethical principle that is being respected and that provides some justification for what is being done.

Besides, there is an ethical presumption which favors cooperation because ordinarily, cooperation is a genuine human good, rooted in the most common sense structure of human beings. We need others to come into being and to survive; we need them for growth, learning, task fulfillments and self-realization. Being at odds with others contributes to a diminishing of the self because we are so closely connected with one another as human beings.

If self-interests require smooth relationships and cooperation, so too does medical practice. A person or group of persons who considers duty and obligation only in terms of what is best for _me_ or _us_, disregards the way human beings are. Therefore, such an individual cannot be ethical. This is especially true of medical persons and groups.

Cooperation, then, is a genuine human good and a basic ingredient of good medical professionals. Situations may develop which make cooperation wrong and require refusal to cooperate, but a general spirit of uncooperativeness can be justified only in the face of a radically evil system.

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**Appendix**

**Distinguishing ethical conflicts from problems of communication**

Conflicts and dilemmas involving different ethical principles create painful situations for nurse anesthetists but are not the only source of problems encountered in the hospital setting. Many problems are more a matter of bad communication than a matter of ethical differences. In fact, terrible conflicts can develop because of ethnic issues, differences in training/education, sexual attitudes and the like, and while there may be ethical aspects to these conflicts, they are not the same as the biomedical conflicts we have focused on in Parts 1 and 2 of this article.

It is very human for those involved in such situations to think and talk about their conflicts in ethical terms. What essentially is not a biomedical issue can be conceptualized in terms of rights and duties, principles and rules which are easily confused with the conflicts and dilemmas we have been discussing. What may sound like a classical nurse-physician conflict about ethics may, however, be a matter of bad communication between two professionals.

For example, one nurse was caring for a patient with cancer. The physician had ordered heavy doses of morphine which kept the patient only partially conscious and completely subdued. In addition, the patient was beginning to show toxic effects from the drug. The nurse's professional principles seemed to be violated because the patient was being harmed and kept from any real communication with her family. After voicing her concerns to the physician, it turned out that he was unaware of the toxic effects of the drugs and of the degree of sedation—he wanted only to keep the patient comfortable. The nurse agreed that this was proper, indeed, it was one of her primary goals as well. Good communication settled what seemed to be conflict of principles. The drug dose was adjusted and both professionals were confirmed in their ethical standards.

This case is simple, but one that makes an important point. Respectful attitudes of professional persons toward one another, joined to basic communication skills, is oftentimes all that is needed to resolve a conflict. It is not that two professionals have conflicting ethical viewpoints, but only that they do not understand one another. Good communication skills frequently diffuse a conflict which essentially results from a misunderstanding rather than from a difference of values.

**The nurse-physician relationship**

The literature on nurse-physician relationships is full of complaints by nurses of bad communication origi-
nating in disrespectful attitudes on the part of physicians. The disrespect takes many forms: being ignored, talked down to, ridiculed, harassed, reprimanded publicly, or blamed unfairly. Some physicians simply seem not to understand the role of the nurse, and they do not appreciate its pressures. When this happens, conflicts multiply which easily become confused with dilemmas of medical ethics simply because the persons involved are medical persons. The ethical aspect of the problem, however, stems from a failure to treat another human being as a primary value and not as a source of a difference of opinion about medical rights and obligations.

Improving communications requires the acquisition both of listening skills and sensitivity to ways of expressing oneself. It includes asking the other professional for opinions, sharing diagnosis and treatment plans, and not forgetting to show appreciation. This type communication, joined to working closely for the good of patients with other professionals can be likened to a good marriage. But, where there is neither good communication nor a good working relationship, the same nurse-physician relationship can resemble less a good partnership than a bad marriage.

Although there is considerable gain to be realized by good communication and great loss incurred if communications falter, improvement and change depend upon an understanding of the long-standing patterns of the old doctor-nurse game. The traditional game set out the rules of communication and diminished conflict by mandating a superficial smoothness and efficiency. In truth however, adhering to these rules required belief about the role and responsibilities of nurses and doctors that today are held by an ever-decreasing minority.

Most nurses no longer see their roles and responsibilities as physician aides but as patient advocates. This change makes the old rules of communication obsolete. But no other system has developed to take its place.

The improvement of communication patterns between doctors and nurses will be brought about not by studying ethics, but by giving more attention to the communication process. This could include learning different theories of human communication as well as mastering recently engineered models of communication. I do not think these theoretical approaches are useless but it is easy to ruin real communication by trying to make it fit some pre-conceived pattern.

If both doctors and nurses make an effort to understand one another's needs, backgrounds and sensitivities, an important first step toward improvement would be taken. Then, certain skills could be learned as to how to communicate in certain settings (during a crisis, when someone dies, if a patient is frightened, when people are under great pressure, and so forth). There are some things which can be learned from books, but not everything. Real improvements in communication come from each person taking the feelings and needs of the other person into consideration.

ADDITIONAL READINGS


Note: An extensive bibliography is available upon request from the author.

AUTHOR

James F. Drane, PhD, holds graduate degrees in Philosophy, Theology, Romance Languages and is an alumnus of the Menninger School of Psychiatry where he studied as an interdisciplinary fellow. He specializes in medical ethics with a particular focus on ethical issues in psychiatry. In 1981, he was a research scholar at the Kennedy Institute for Bioethics, Georgetown University, and currently he is doing research on competency to give or refuse consent to medical treatment at the University of Tennessee Center for the Health Sciences in Memphis. Dr. Drane currently teaches philosophy at Edinboro State College in Edinboro, Pennsylvania and at the Warren State Hospital Psychiatric Residency training program. This article is based on his presentation at the Student Luncheon at the 49th AANA Annual Meeting and Professional Sessions in Boston, Massachusetts, August 31, 1982.